United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

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Submitted By: Maria Laurence, MPA, Monitor

Monitoring Team: Victoria Lund, Ph.D., MSN, ARNP, BC
Edwin J. Mikkelsen, MD
Antoinette Richardson, MA, JD
Susan Thibadeau, Ph.D., BCBA-D
Nancy Waglow, MS, MEd
Wayne Zwick, MD

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I. Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) component of Rio Grande State Center.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

The Monitor's role is to assess and report on the State and the facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

II. Methodology

In order to assess the Facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents, as well as request additional documents for off-site review.
(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.
(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.
(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the Facility.

III. Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement.

This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;

(c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;

(d) **Assessment of Status:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and

(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.

(g) **Individual Numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

IV. Substantial Compliance Ratings and Progress

Across the State's 13 Facilities, there is variability in the progress being made by each Facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation of the parties who crafted the Settlement Agreement was for the State to make systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the Facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/ID regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a Facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report to identify the Facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the Facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity. Some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, Section L.1 addresses the total system of the provision of medical care at the Facility. This is in contrast with Section T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each Facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the Facility will obtain substantial compliance with 25% of the provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement. This is due to the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the Facility (as was the intent of the parties).

V. Executive Summary

Although as this report illustrates progress had been made in a number of areas at Corpus Christi State Supported Living Center (CCSSLC), serious concerns continued to exist that impacted individuals' health and safety. Similar to what the Monitor did in the report for Corpus Christi dated July 17, 2013, the following summary provides information about some of the most significant concerns the Monitoring Team identified in the hopes that attention will be paid and solutions implemented to address these concerns. Unfortunately, at the time of the Monitoring Team's review, neither

the Facility nor the State Office had the mechanisms in place to identify and redress such issues. Some examples of serious concerns included:

- Individual #72 who left the Facility without authorization after his team significantly reduced his level of supervision (LOS) from one-to-one to routine was found dead weeks after leaving the Facility. The DFPS investigation found systems neglect. Based on the Monitoring Team's review of investigation materials and discussions with staff prior to and during the onsite review, several concerns existed with regard to State Office and Facility staff's follow-up to this tragic incident. For example:
  - One recommendation resulting from the investigation was for the Facility to review its use of enhanced staffing in order to provide an intermediate alternative between routine level of support and one-to-one supervision. Although the Facility was in the process of finalizing a new policy related to levels of supervision, neither the Facility nor State Office articulated a plan describing how the outcome of such changes would be monitored, or how the State Office Quality Assurance staff or Facility staff would determine if proper levels of supervision were in place for other individuals for whom teams might have reduced supervision levels. These were essential follow-up activities to ensure that individuals were protected from harm.
  - Similarly, the State Office and/or Facility had not identified the full scope of what needed to occur to protect others from harm. Although it is important for teams to ensure the least restrictive levels of supervision are in place, it is essential that the process for reducing levels of supervision for behaviors that have the potential to place the individual at risk is carefully orchestrated with the involvement of Board Certified Behavior Analysts (BCBAs). At the time of the onsite review, the Facility had not nor had State Office Behavioral Health Services staff identified the need to standardize processes for reductions in supervision levels or other restrictive practices. As was discussed while the Monitoring Team was on site, when fading restrictive practices, including, but not limited to one-to-one staffing or enhanced levels of supervision that have been in place due to risky behaviors, staff should attend to the following guidelines:
    - Brief attempts to fade restrictive practices or increased levels of supervision should be probed by clinical staff who should then develop carefully designed written programs for direct support professionals to implement.
    - Fading programs should include the following:
      - Objective measures of operationally defined successful behavior(s) and behavior(s) that would trigger reconsideration of attempts to fade supports;
      - Frequent and structured assessment of preferences so potentially powerful reinforcers are applied to ensure positive behavior change; and
      - Ongoing oversight and supervision by Behavioral Health Services staff.
    - Consideration should be given to presenting all fading plans to internal and external peer review.

- Based on the Monitoring Team's review of a small sample of ISPs for individuals for whom teams had reduced supervision levels in recent months, adequate team reviews had not been completed, appropriate planning had not occurred, and it did not appear that individuals were adequately protected from harm. For example:
  - On 1/9/14, Individual #310's one-to-one supervision for pica was reduced. His ISP of 12/3/13 had indicated it was necessary to keep him safe. The nursing assessment indicated that the previous year, he had "multiple successful episodes of pica including ingesting hand sanitizer and leaves. This year he had only two episodes of ingesting flowers; he was non-compromised both times. This decrease in pica episodes is largely due to his 1:1 LOS." The Comprehensive Psychological Assessment, dated 1/24/14, showed a spike in pica attempts in November 2013 (i.e., 19 attempts). The 1/9/14 Individual Support Plan Addendum (ISPA) made no reference to these assessments and indicated that: "[Individual #310] has not had any attempts at pica or pica attempts [sic] during his noon meal. He has not tried to steal food from other individuals. The team agreed to have him on routine supervision during all three meals. Routine on 10-6 shift and in the game room (den), 1-1 at all other times." The team did not provide adequate justification for its decision, nor did it present a plan to ensure that Individual #310 remained safe during the process of reducing staffing supports (i.e., no plan was set forth to conduct probes to determine whether or not he would attempt pica as the one-to-one staffing was reduced).
  - Individual #297's ISP, dated 10/15/13, included one-to-one staffing, except after 20 minutes of her falling asleep. This level of supervision was in place due to her high risk of aspiration and choking, and her attempts to ingest food and non-food items, including liquids. To remain safe, she was supposed to have nothing by mouth and received all nutrition and medications through a gastrostomy tube (G-tube). In July 2013, she had three restraints due to attempts to ingest food items. On 11/20/13, the interdisciplinary team (IDT) met to "review LOS." The team decided on the following plan: "If [Individual #297] goes 7 days without SIB or ingestion of food or drink items, the IDT will review for possible addition of 30 minutes in Routine LOS while in the living room area. The reduction plan will continue weekly." The team indicated this would occur from 4 to 5 p.m. in her residence. However, no plan was outlined to conduct probes to determine whether or not without the higher level of supervision, she would engage in behavior that put her at risk. For example, no plan was in place to determine if food items were available in the environment during times when supervision was reduced, if she would attempt to ingest them. Clearly, in order to test her safety, a situation would need to be set up in which staff could see her and reach her quickly, but she did not know they were watching her. In addition, it did not appear from the ISPA that the team considered any alternatives between one-to-one supervision and routine.

        - Individual #159's team identified her as being at high risk for choking and aspiration due to pica. At the time of her ISP, the team identified one-to-one supervision to keep her safe. Little to no data was included in the IRRF related to the current status of her pica behavior or the replacement behavior(s). At the time of the ISP meeting, it appeared her one-to-one level of supervision remained in place. However, there was no description of what the one-to-one staffing involved, or how the team would assess in the future its continued necessity. For example, the IHCP only stated "1:1 LOS," but did not define the role of the staff, their proximity to her, etc. Similarly, the IHCP stated: "Do environmental sweeps to remove items from surroundings that could be ingested," but the frequency was not defined, nor were the items that should be removed. In addition, no objectives/goals related to reducing the pica or increasing replacement behaviors were included in the IHCP.
    - In summary, the lack of urgency with which the State Office and Facility were addressing the issues uncovered through the investigation of the circumstances surrounding Individual #72's death were extremely concerning. Of equal concern was the lack of intervention of State Office's Behavioral Health and Quality Assurance staff in ensuring that the Facility had the resources, knowledge, and skills to address the issues identified, and to provide external monitoring and oversight to ensure that other individuals potentially impacted by the gaps in the system were quickly and thoroughly addressed. This was particularly important given that the Behavioral Health Services Director position at the Facility had been vacant at the time the initial incident occurred, and a new Director had just begun at the Facility in the weeks before the Monitoring Team's visit.
- The Combined Data Report for January 2014 showed one individual (i.e., Individual #348), who had been identified as involved at a high level in seven of eight major data collection categories, such as abuse/neglect, injury, peer-to-peer injuries, and crisis intervention restraint. However, no plan of correction was in place. Such a finding should have triggered further investigation and an outside look beyond referral back to the Interdisciplinary Team.
- In recent months, four individuals had sustained hip fractures. This should have resulted in an interdisciplinary review and analysis to determine potential common causes and to identify any necessary corrective actions. However, there was no evidence of the Quality Assurance/Quality Improvement Council's review/analysis of this information and/or action plans to address the findings. The following provides more detailed information about one of these fractures:
    - DFPS report #43074881, which investigated an incident that occurred on 3/27/14, was reviewed because it involved a comminuted hip fracture (one in which the bone is broken in multiple places) of unknown origin. The DFPS report confirmed that there was a failure by an unknown person to recognize or react to trauma or that staff used improper transfer methods that resulted in the fracture. However, no alleged perpetrator could be identified. The report recommended that staff provide closer

supervision and be alert to anything that might cause trauma and that the vehicle drivers maintain logs on the vehicles so that it would be possible to identify who was driving when individuals were transported. At the time of the Monitoring Team's review, the Facility had not completed its internal review of this incident. However, in its response to the draft report, the State indicated that the Facility had agreed with the findings from DFPS, and added a recommendation that any employee working during the time the incident likely occurred would complete retraining on lifting and transfers. No other recommendations were included related to, for example, increased monitoring of staff during lifting and transferring or other activities during which individuals were at risk.

- The Monitoring Team continued to find that staff were not implementing Physical and Nutritional Management Plans (PNMPs) as they were written, placing individuals at risk. This is discussed in greater detail with regard to Section O.4 of the Settlement Agreement. However, the following examples of the Monitoring Team's observations were further evidence of the DFPS findings related to staff members' use of improper transfer methods:
  - During the Monitoring Team's observations, two staff transferred an individual from her wheelchair to a bathing trolley for check and change. The transfer was poorly performed, because the area was not cleared to ensure safety, the staff did not communicate with each other or the individual, staff were using poor body mechanics, the transfer was performed too quickly, and the individual was not lowered slowly to the bathing trolley.
  - During the observation of a mechanical lift transfer, the Facility therapists and PNMP Coordinators had to intervene from the beginning to the end of a mechanical lift transfer. Staff did not have the correct sling as prescribed on the PNMP. The correct sling had to be located and placed under the individual. The staff conducting the transfer did not place the correct sling properly, and the PNMP Coordinators had to intervene to fix the placement of the sling. In addition, the two staff were not positioning themselves correctly to ensure safety to the individual's arms and legs as the mechanical lift was being raised. The Facility therapists and PNMP Coordinators had to continually prompt the two staff throughout the mechanical lift transfer and finally had to demonstrate the correct techniques. The Facility therapists and PNMP Coordinators were in agreement with the Monitoring Team that these transfers were poorly performed.

  Unfortunately, as discussed with regard to Section O.6 of the Settlement Agreement, the Facility's own monitoring activities were not identifying these issues. As stated during multiple reviews, the correct implementation of PNMPs by staff should be addressed urgently. This should be a major focus over the next six months. To succeed in this endeavor, it will be important to use an interdisciplinary problem-solving approach to analyze why staff are not implementing PNMPs, and then implement strategies to reverse this ongoing practice.

- In addition, based on the Monitoring Team's review, fractures were not being consistently reported for investigation, and as noted above, patterns of fractures were not further reviewed/analyzed, and as a result, the need for further action likely was not identified:
    - Specifically, when comparing the list of fractures provided to the physician on the Monitoring Team (IX.24B) with the list provided for Section D of serious injuries that were investigated, it appeared that several fractures to fingers or toes were not reported for investigation. These included injuries to Individual #58 on 8/3/13, Individual #304 on 8/28/13, Individual #161 on 9/5/13, and Individual #186 on 1/16/14. According to the Incident Management Policy, a serious injury is any injury requiring medical intervention by a physician, physician's assistant, or advanced practice nurse, and requires reporting for investigation. It was not clear why these injuries were not reported. In addition, Individual #356 who had sustained a non-displaced fracture to the distal right fibula on 9/11/13 did not appear on the list of investigations. This suggested that serious injuries might not have been reported for investigation or might not have been recorded in the data system. If true, this would mean the reports generated through the data system were unreliable.
    - Another issue involved the presence of at least four hip fractures noted by the Monitoring Team's physician in the last six months. Three had been investigated and a fourth had not. All four of the fractures should be reviewed for any commonalities of practice that might have contributed to the injuries and if there were any, action should be taken to address the underlying causes.
- A review of the clinical and administrative death reviews revealed the need for improvement. One of the individuals died in the hospital, but during the interval of time prior to transfer, at least one medication error had occurred. Increased monitoring followed and the individual was subsequently hospitalized. This medication error was categorized as a Category C, when it was a Category F that should have led to a root cause analysis. When departmental leadership was asked the reason for the medication variance, there was no clear answer given. The Monitoring Team member then met with the Pharmacy Director, who provided an in-depth review of the circumstances involving the medications. Some of the information had not been previously available, but should have been part of a root cause analysis. The Pharmacy Department provided clear evidence as to the number of doses administered and not administered, indicating medication was available but not administered. Due to the fact that no root cause analysis was conducted, the cause of the incident was never determined. Although there was Nursing Department training of all staff concerning a policy already in place, until that reason is determined, the Facility cannot be assured that the preventive steps taken have resolved the problem.
- Similarly, a review of Potentially Disrupted Community Transition ISPAs revealed that CCSSLC teams were not conducting critical reviews of the transition planning and implementation processes to ensure that corrective action was taken to prevent negative outcomes from recurring for other individuals transitioning to the community. For example:

- Shortly after his transition to the community, Individual #47 was on a community outing when he ran from a restaurant, ran onto the freeway, and died after a vehicle hit him. Although it is difficult to determine what might have prevented his death, the team for Individual #47 did not conduct a critical review of the transition planning or implementation processes following his death. The team, including members of the CCSSLC team and the community provider team, simply concluded that Individual #47 did not have a history of running away, and nothing could have been done to prevent the event that caused his death. The team did not carefully review the transition process and the supports included in the Community Living Discharge Plan (CLDP) to determine what might have been missing. Based on the Monitoring Team's review of the CLDP and related assessments, assessments necessary to obtain a full picture of his needs were missing and would have been important for the team planning his transition, and numerous supports were missing from his CLDP, including, for example, definition of staffing supports, supports to address his tendency to get lost, and psychiatric and behavioral/psychology supports to address a history of hallucinations that told him to harm himself, and a history of increased behaviors when transitions occurred for him on the CCSSLC campus. These concerns are discussed in greater detail regarding Section T.1.f of the Settlement Agreement.

- On an individual basis, teams were not acting to protect individuals. In the past, as part of the ISP process, the Monitoring Team had recommended an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment had begun to be included in the ISPs. However, this often appeared to involve a cursory review of the incidents and allegations. It was not clear that the goal had been met of individuals' teams ensuring that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place and appropriately incorporated into the ISP. Most often, the teams did not adequately analyze the information and/or identify areas in which changes might be made to attempt to reduce the frequency of such occurrences. Some example of concerns noted included:
  - Although the team identified that Individual #297 had a trend in self-injurious behavior and that three restraints had occurred due to self-injurious behavior (SIB), they simply concluded that she had a PBSP. No review was documented to show the team considered whether or not the PBSP was effective, or whether changes to the PBSP had occurred or were necessary. She also had a trend as a victim of peer-to-peer aggression, but the team simply concluded that one of the peers had moved, and the other two had PBSPs. No consideration was given to whether current living arrangements were appropriate, or whether actions were needed to help her protect herself.
  - For Individual #298, although the team discussed the incidents, they did not document meaningful discussion of clear trends. For example, Individual #298 had 32 incidents of peer-to-peer aggression, with 23 of them being with the same individual. Although the team described actions being taken with the other individual (e.g., medication and BSP changes), there was no discussion of other alternatives, such as not having the two women live together. Similarly, she had 42 incidents of SIB, but the team did

not discuss this in any detail. Although the team referenced the PBSP's focus on aggression, the team did not discuss, or document discussion of the PBSP's effectiveness in addressing SIB.
    - The ISP identified the incidents that had occurred, but showed no analysis or action to address potential trends, including seven peer-to-peer incidents in which Individual #310 was the victim.
- At the time of the Monitoring Team's last review, the Monitor met with the Facility Director, Assistant Director of Programs, and several discipline leads. At that time, the critical need to review of the supports of Individual #333 was discussed. However, at the time of the most recent review, little if any action had been taken to address his needs. For example:
    - Individual #333 was a young man, but since his admission to CCSSLC he had begun to refuse to walk, and although he would eat fast food, refused to eat most of the Facility's food, and, as a result, had a G-tube inserted. The team did not have a plan to reduce his reliance on the feeding tube. He also recently had sustained a broken hip.
    - The Facility reported that Individual #333 did not have a PBSP. This was concerning, because other documents indicated that he engaged in self-injurious behavior and aggression. In addition, Behavioral Health Services staff should have been involved in assessing his refusals to get up or walk, and his refusals to consume certain foods orally. These were clearly issues that the interdisciplinary team should have addressed, with the lead taken by Behavioral Health Services staff.

The State Office and Facility are strongly encouraged to address these overall protection from harm issues as quickly as possible.

The following is a brief summary of Corpus Christi SSLC's status with regard to relevant sections of the Settlement Agreement:

Restraints

- The Facility had made progress in the management of the use of restraints, including:
    - There was a new Director of Behavioral Health Services, who began work in March 2014.
    - The use of restraints for crisis intervention appeared to be continuing to decline, but the methods for counting restraints had changed several times, and it was not clear whether the decline was a true decline or the result of those changes in counting methods. While it was encouraging to see a decline in restraint use, the safety of individuals is of paramount importance and it is important that low restraint use is not achieved at the expense of individual safety.
    - The dates of reviews by the Unit Interdisciplinary Team (IDT) and the Incident Management Review (IMRT) were being documented on the Restraint forms on a more regular basis.

- There had been a clarification of the nursing protocols that were used for monitoring medical restraints and anesthesia.
- The use of Protective Mechanical Restraint for Self-Injurious Behavior (PMR-SIB) remained low.

- Some areas were identified that needed attention, including:
  - Clarification was needed of where staff were to document information about the behavior prior to the behavior that caused a restraint and this information needed to be documented on a regular basis.
  - The Facility should consider reducing the number of restraint monitors and enhancing their training on monitoring restraints and how to use the monitoring forms.
  - Unit Team and IMRT meetings that the Monitoring Team attended included some good discussion, but the minutes needed to reflect consideration of accuracy of the documents presented, whether the restraint was necessary given the situation, whether there was a need for the IDT to meet to address any issues, and whether there were any other recommendations that needed to be addressed.
  - Key indicators of performance needed to be identified to track progress.
  - When medical/dental restraints were used, the physician needed to specify the type and frequency of monitoring that was to be done, and then the monitoring needed to be carried out as ordered.

<u>Abuse, Neglect and Incident Management</u>

- During this review, the Monitoring Team found the Facility to be in substantial compliance with 18 out of 22 provisions of Section D, which was the same number of provisions that were in compliance during the last review. Progress was noted in a number of areas. Highlights of progress included:
  - The Incident Management Coordinator's (IMC's) supervisory forms documented changes needed to complete reports and those changes were generally carried out. There was evidence that additional supervisory review of Unusual Incident Reports (UIRs) was ongoing, including marking up the preliminary UIR and returning it to investigators for corrections, as the report was moving toward its final version.
  - The Review Authority Team (RAT) findings augmented the recommendations on each report, adding to or correcting the UIR.
  - A tracking log for the recommendations that emerged from UIRs, Department of Family and Protective Services (DFPS) reports, and the Review Authority Team had been added to ensure timely submission of evidence that the recommendations had been implemented.
  - An Executive Safety Committee had been established to analyze trended data and to make recommendations for program changes.
- Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included the need to:

- Establish the process for auditing injuries and include investigation of unusually large numbers of injuries or large numbers of peer-to-peer injuries, or patterns of injuries that are discovered either through the audit process or through the monthly reviews of trend data.
- Load the Quality Assurance (QA) monitoring data into the system so that it can be compared with the IMC unit data to establish a healthy check on performance and reference that data in the Facility Self-Assessment.
- Review the recommendations from investigations involving unauthorized departures and ensure those recommendations fully address the issues identified and are fully implemented. In addition, for the protection and improvement of the lives of all individuals who live at the Facility, as appropriate, recommendations should address systemic issues that have the potential to impact others, and should not be viewed as isolated to the specific individual or circumstance. For example, issues related to teams' assignment of levels of supervision should be addressed across campus, and not just for individuals for whom higher levels of supervision were assigned due to histories of unauthorized departures.
- Improve the timeliness of UIRs, both those that follow DFPS investigations and those that are Facility-only investigations.

<u>Quality Assurance</u>

- Since the Monitoring Team's last monitoring visit, the Facility had made some progress with regard to Section E, including:
  - The Data Inventory had been refined and updated, providing an excellent overview of the data available at the Facility and the reports that were generated from the data.
  - The Quality Assurance (QA) Plan had been reviewed and revised to include descriptions of QA personnel.
  - A preliminary listing of key indicators was available.
- Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included:
  - While the QA plan had been improved to include reference to the data inventory and specific descriptions of the responsibilities of QA staff, there were a number of adjustments needed, such as adding a section on Key Indicators under the data collection/analysis and a section describing the responsibilities of other departments. This should include a description of the role of the Facility Director in relation to quality assurance efforts.
  - A list of key indicators was under development, but it was not clear that the list was finalized, what data was being collected, or how the data for the key indicators would be managed, reported, or addressed. The list presented was extensive and in need of review by Section Leads with some editing to reflect the priorities of the Facility. Whatever indicators are finally adopted, data sources will need to be identified for each indicator. A lot more work needs to be done to design methodologies for the collection of accurate data for indicators, as well as to set benchmarks or target goals.

- The monitoring tool for Section E needed revision to provide a valid assessment of progress toward substantial compliance.
- The Corrective Action Plans (CAPs) tracking needed to include the method and dates of dissemination, and name of the person responsible for assuring the dissemination is completed.
- A system was needed to measure whether or not CAPs were achieving the desired outcomes, and, if not making revisions to the plans.
- CAPs needed to address issues, identified through data collection and analysis. The Facility should consider having the Program Compliance Monitors (PCMs) take a more active role in assisting Section Leads to analyze data and select potential CAPs.

<u>Integrated Protections, Services, Treatments and Supports</u>

- The Facility developed and was implementing the Assessment Review Committee. Based on observation during the week of the onsite review, the Assessment Review Committee provided a valuable forum to effectuate improvements in specific components of assessments, such as identification of needs, the incorporation of individuals' preferences and strengths, the quality of recommendations, the goals recommended, and barriers to reaching the goals. The Committee used a peer-review format, and a specific audit tool was used to guide the discussion and provide feedback to team members. Overall, this Committee was a positive addition that should assist in improving the quality of assessments.
- Since the last review, CCSSLC had revised its ISP Monitoring/Monthly Review Process policy. This revised policy shifted the focus to integrated monthly reviews, and included roles for team members other than the QIDPs, including, the RN Case Managers, Residential Coordinators, and the Behavioral Health Specialists. Although this format did not yet cover all of the aspects of the ISP and IHCPs, as the Settlement Agreement requires, it was a significant improvement over the previous format, and included some important components that helped to provide a more rounded picture of the individual on a monthly basis. In addition, the revisions included a cumulative record of the individual's status throughout the ISP year. Based on a review of a sample of monthly reviews that had been completed using the new format, it was easier to quickly see when progress had occurred or was lacking. This should assist teams in determining when action is needed.
- Examples are provided in various sections of this report of individuals experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to medical and nursing care, as well as physical and nutritional management supports. Although clearly more work needed to be done, it was positive that the new monthly format drew attention to this issue by including sections on changes of status, as well as Infirmary Admissions and hospitalizations. Improvements in the measurability of goals and actions steps related to the identification of individuals' changes in status and then monthly (and more frequently as necessary) review of this data will be necessary for teams to identify changes of status early and respond accordingly.

- Teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences.
- Although some limited improvement was seen, ISPs generally continued to lack measurable objectives necessary to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, or maintaining his/her current status).
- Different audits were completed for the Self-Assessment for Section F and for the internal quality improvement function. It appeared that this was due to the need to complete the indicators that State Office required for Section F for the Self-Assessment, and the Facility's recognition that different indicators would be more helpful. The Facility should work with State Office to develop an audit process the results of which can be used for both the Self-Assessment and internal quality improvement processes

Integrated Clinical Services

- The Integrated Clinical Services Team (ICST) meetings were one forum that demonstrated inter-departmental critical discussion and collaboration in responding to acute changes in status, such as hospitalizations and Emergency Room (ER) visits. The meeting was well attended by numerous departments, and there were opportunities for several departments to provide periodic updates in addition to the daily discussion of those acute health and behavioral changes of status.
- Improvement was needed with regard to follow-through and timely response for post-hospital Individual Support Plan Addenda (ISPAs), as well as the content of those ISPAs in addressing health concerns. For example, From August 2013 through January 2014, there were 42 ISPAs completed for individuals that had been hospitalized or admitted to the Infirmary. The average length of time varied per month from eight days to 31 days. Average time to completion from August 2013 through January 2014 was 17 days. Considerable support needs to be provided by Facility Administration to ensure timely completion of these ISPAs. The delay in ISPA development and implementation potentially could affect the health and safety of the individuals, especially those recently hospitalized.
- One or more of the open record reviews were of high quality and provided additional perspective and opportunities to address individuals' health needs.
- The Facility used an extensive audit tool to review consultation reports, including the Primary Care Providers' (PCPs') interpretation of the consult reports. There were no examples provided of consults that needed timely IDT response through the creation and implementation of new ISPAs. A tracking mechanism to focus on those specific consults is needed. For the many clinical indicators related to response to consultations, the Facility's data showed good results, but additional focus was needed on measuring the IDT response, where necessary. The Medical Department had already identified this need, and interdepartmental communication had begun.
- Another important forum in which integrated clinical services were necessary was the ISP process. There needed to be further training of Qualified Intellectual Disabilities Professionals (QIDPs) and teams in determining which departments were essential to attend each ISP meeting.

- The Medical Department appeared to have made great strides with regard to Sections G.1 and G.2. Other departments needed to reflect similar progress and momentum in order for the Facility to be in substantial compliance with Section G.

Minimum Common Elements of Clinical Care

- The Dental and Pharmacy Departments completed their required periodic assessments in a timely manner. The Medical Department continued to need improvement, although progress had been made for both annual exams and the quarterly medical reviews.
- The Facility did not yet have a process in place to accurately identify assessments needed for ISP meetings. QIDP Department staff recognized work was needed to ensure that when teams met for ISP Planning meetings they consistently identified necessary assessments based on individuals' needs and preferences, or that teams provided adequate justification for not requiring such assessments.
- There was continued auditing by external medical peer reviewers, as well as internal medical peer reviewers in determining whether the common elements of clinical care were occurring. Additionally, the Medical Department had begun to expand the number of internal quality monitoring tools, and had implemented a number of these over several months, with data that was analyzed. A strong quality improvement process needed to be demonstrated (i.e., was the analysis followed by identification of areas needing improvement, followed by evidence of development and implementation of a corrective action plan, followed by follow-up audits to determine impact of the implemented action plan).
- An expansion was needed of the areas measured for quality [e.g., not only were certain standardized tests ordered per diagnosis, but was there prompt and appropriate response to abnormalities (i.e., physical findings, lab tests, etc.)].
- These also needed to be links to outcomes for individuals, and measurement of the efficacy of treatment. IHCPs were still not written in a manner that described all of the treatments and interventions that individuals required. Nor did the current IHCPs allow determinations to be made regarding whether or not such treatment and interventions were provided in a timely manner or if they were effective. When treatment was not effective, then teams needed to review treatments and consider modifying them, as appropriate.

At-Risk Individuals

- At the time of the review, the Facility had experienced staffing challenges, including an extended leave of absence of the Section Lead for Section I. Unfortunately, this had resulted in data gaps for the review period, because data were not accessible to the Facility staff at the time of the review. In addition, the Facility had experienced a loss of some of the gains it had made at the time of the previous review in relation to the identification of key compliance indicators to measure the quality of the supports and documentation for Section I in alignment with the Settlement Agreement requirements. It is essential that the Facility designate a dedicated Section Lead for this area in order to continue to move forward regarding the at-risk system.

- On a positive note, the Facility had initiated a promising tracking system regarding changes of individuals' status at the residence level before individuals were admitted to the Infirmary or community hospital. Addressing changes in status at this point was the Facility's first step in ultimately being able to proactively provide supports of the needed clinical intensity to attempt to prevent acute illnesses that might require a transfer to another environment.
- In addition, in January 2014, the Facility had initiated the Assessment Review Committee to ensure individuals' strengths, preferences, and goals were included in assessments. Also, since the last review, the Facility developed a flow chart to assist the teams in determining what type of Individual Support Plan Addendum (ISPA) to initiate: a regular ISPA, Unusual Incident ISPA, or a Review for Change of Risk level.
- Although the Facility continued to invest a great deal of effort in building the At-Risk system at CCSSLC, there continued to be an overall lack of clear documentation included in the ISPs, the Integrated Risk Rating Forms (IRRFs), the Integrated Health Care Plans (IHCPs), and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues.
- Although the Monitoring Team observed some positive practices at the ISP meetings held during the onsite review, there continued to be significant problematic issues regarding the accuracy of the risk levels, the reflection in the IHCPs of supports of the necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this process.

<u>Psychiatric Care and Services</u>

- The Monitoring Team conducted a streamlined review of Section J due to previous sequential substantial compliance ratings for five of the 15 subsections. Specifically, no monitoring was conducted of Sections J.1, J.2, J.6, J.7, and J.12.
- Previous calculations indicated that two full-time equivalent (FTE) Psychiatrists would be adequate to provide psychiatric services to the 105 individuals receiving psychiatric medication. The current group of Psychiatrists collectively accounted for 2.25 FTEs. In addition, the Chief Psychiatrist stated she had viable candidates for the open Psychiatrist block.
- The psychiatric diagnosis was discussed in multiple places in the record. The Psychiatry Department actually replicated the relevant Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) criteria that substantiated individuals' diagnoses. The spreadsheet the Psychiatry Department maintained to track the status of the CPEs indicated that all of the annual updates were current. Quarterly reviews were conducted timely, and included the necessary components.
- With regard to the use of pre-treatment sedation for medical and dental procedures, the Facility still had considerable work to do, because at the time of the onsite review, there were only 11 Pre-treatment Desensitization Plans implemented, and all related to dental visits, and none addressed the need for medical pre-treatment sedation.

- With regard to risk-versus-benefit analysis and informed consent, a member of the Monitoring Team was able to attend the HRC meeting that took place during the onsite review and found the discussions to be thorough. The Pharmacy Department also provided another level of review of the consent process, in that they did not dispense a new psychiatric medication unless they physically saw a copy of the signed consent form. The current review found that the consent process was being uniformly implemented.
- The spreadsheet the Facility maintained indicated that from 8/1/13 to 4/2/14, a member of the Psychiatry Team had attended 64 of 68 (94%) of the ISPs for the individuals they follow. The documentation in the ISP had improved considerably since the Monitoring Team's prior review. However, there were continuing concerns about the documentation of the actual discussions that took place during the ISP meetings.
- A member of the Monitoring Team attended the Polypharmacy Meeting during this onsite review, and the rates of polypharmacy continued to decline. The Department also had assembled convincing evidence for those whose medication regimens they believed could be clinically justified.

Psychological Care and Services

- At the time of the review, the Behavioral Health Services Department had just hired a new Director after six months with this position vacant. Through interviews and observation, it was clear that the new Director came with extensive experience and qualifications.
- Areas where concerns were noted were in staff progress in demonstrating competence in applied behavior analysis, data collection, consistent peer review as well as demonstration of the use of the recommendations resulting from the reviews, and provision of counseling services. Continued improvements were needed with regard to the content of monthly progress reports, as well as follow-though on recommendations included in the reports.
- With regard to Positive Behavior Support Plans (PBSPs), a focus for the future should be the development of plans with clear methodology and adequate schedules of teaching identified replacement behaviors, enriched and specific schedules of reinforcement for appropriate and alternative behaviors, and expanded prevention strategies.
- Areas of strength were in current assessment of cognitive and adaptive behavior skills.

Medical Care

- The Medical Department had made some good progress. The data the Medical Department produced appeared to be complete, accurate, and reliable. The pneumonia data was no longer confusing, but appeared to be based on one accurate database for all requests. Preventive care tests and procedures appeared to be tracked to completion.
- There had been a reduction in the number of hospitalizations in recent months. The implementation of the "unstable vital sign protocol" might have had an impact on reducing the hospitalization rate.
- The ICST meeting appeared to continue to grow and participants reviewed acute health status change of individuals that resided at CCSSLC, and tracked individuals admitted to area hospitals. To allow tracking of

timely follow-up to concerns the group identified, the goal should be to have the final Integrated Clinical Services Team meeting minutes available the next day, but currently a system was not in place to allow this to occur.

- The quality of the quarterly medical reviews had improved. However, ensuring annual medical assessments and quarterly medical reviews were completed in a timely manner was a continuing challenge. Other challenges related to the clinical care of individuals included, for example:
    - With regard to identifying secondary causes for osteoporosis for men, information the Facility submitted suggested significant need for treatment of testosterone levels and Vitamin D levels. However, the testing done to make this determination did not appear to have been synchronized with the annual medical assessments, or at other times when blood work was drawn routinely. That the lab testing occurred recently appeared to indicate testing was done to fulfill the Monitoring Team's request for information. The number of abnormal findings indicated that treatment had not been optimized for osteoporosis/osteopenia in a significant number of individuals.
    - Similarly for women with osteoporosis/osteopenia, lab tests for twenty-nine of 69 women (42%) indicated abnormally low Vitamin D levels. All lab tests results were from February 2014, and appeared to be a response to the Monitoring Team's request for information. The number of abnormal findings also indicated that treatment has not been optimized for osteoporosis/osteopenia in a significant number of individuals.
    - The Facility submitted evaluations for dysphagia and gastroesophageal reflux disease (GERD) for seven individuals that had acute respiratory distress requiring an ER visit or hospitalization. Review of this information suggested the need for further review to ensure thorough evaluations of GERD in those with acute respiratory distress.
    - In recent months, four individuals had sustained hip fractures. This should have resulted in an interdisciplinary review and analysis to determine potential common causes and to identify any necessary corrective actions.
- For 10 of the 22 individuals with Do Not Resuscitate (DNR) orders in place, clinical justification had not been established. This placed individuals at risk of not receiving appropriate treatment. The Facility had not held Ethics Committee meetings in the months since the Monitoring Team's last review.
- The quality of the death reviews needed to be critically analyzed, with development of criteria/events that would then trigger a root cause analysis. Much can be learned from a critical review of events surrounding a death, with the goal of implementing systems to prevent recurrence, protect the individuals form harm, and provide the needed support to staff. Without such a rigorous system, the death review process will represent a missed opportunity for learning and improvement.

Nursing Care

- From a review of the Facility's nursing staffing data and discussions with the Chief Nurse Executive (CNE), since the last review, the Nursing Department had continued to experience staffing challenges and in January 2014, began using agency nurses to decrease overtime and assist in retention of current nursing staff.
- Some of the Facility's positive steps forward included:
    - The Facility continued to monitor the process addressing data reliability, to accurately identify the Facility's trends related to infectious and communicable issues. From data generated by comparing the Infection Control Reports, Infection Control Logs from the residences, and the Pharmacy reports for the utilization of antibiotics, the following compliance percentages reflected the data reliability checks for Infection Control: 97%, 100%, 100%, 99%, 100%, and 98% from August 2013 through January 2014, respectively.
    - Based on the ISP schedule, the Facility continued to review individuals' complete immunization histories and update any needed laboratory work or immunizations, as appropriate. At the time of the review, 71% of the individuals had had their immunization information brought up-to-date.
    - In January 2014, the Facility conducted its first clinical review of the Mock Code Drills at the Nursing QA meeting. In addition, in February 2014, staff from the Competency Training Department and the Nurse Educators also met to review the Emergency Mock Code Drill data.
    - Regarding nursing assessments, it was clear to the Monitoring Team that the Facility was in the beginning stages of focusing its efforts on improving the documentation contained in the Comprehensive Nursing Assessments. Although not consistently found in most of the assessments the Monitoring Team reviewed, improvement was noted regarding the Summary Section of the Comprehensive Nursing Assessments.
    - In addressing medication variances, in November 2013, nursing had assumed responsibility for the medication excess/shortage forms. The Nurse Managers were responsible for investigating all unknown excesses and shortages in their buildings. The Facility's Unreconciled Medications data from 8/1/13 through 1/31/14 reflected that progress had been made in identifying the causes for unknown excesses and shortages of medications.
- Clearly, the Facility had made steady positive steps forward in the areas noted above. However, there continued to be an overall lack of progress found regarding the care plans, the implementation of nursing protocols for existing conditions and documentation in response to changes in status, which was very concerning at this juncture in the review process.

Pharmacy Services and Safe Medication Practices

- Since the Monitoring Team's last visit, the Pharmacy Department had added two clinical PharmDs, which should assist in more rapid movement towards substantial compliance. The Pharmacy and Therapeutics (P&T) meetings had updated information and encompassed the spectrum of pharmacy concerns. The medication

variance category of unknown excess returns appeared to have been nearly eradicated, due to numerous steps the Pharmacy Department had taken. There was a system in place, with database development in process, to track individuals with seizures to determine if medications were missed for any reason. The adverse drug reaction (ADR) process appeared complete with evidence of training appropriate staff from several departments, as well identification of adverse drug reactions, and reporting of analysis for further discussion at the P&T meetings. The drug utilization evaluation (DUE) process appeared to be mature, and a system was in place to conduct follow-up of prior DUEs.

- The new order process needed strengthening. A new PharmD noted the lack of essential components while completing a detailed audit. The submission of evidence for various types of new order categories had remained a challenge in achieving compliance. A system needed to be in place for the Pharmacy Department to complete timely review of chemical restraints. For Quarterly Drug Regimen Review (QDRR) completion, the Pharmacist needed to address abnormal lab values with comments or recommendations. The Primary Care Practitioners (PCPs) needed to meticulously respond to any recommendations in a timely manner. As the reasons for medication variances become identified, the Pharmacy Department is encouraged to continue to implement new system processes to support its own staff and the Nursing Department in reducing such occurrences.

<u>Physical and Nutritional Supports</u>

- The Facility's Physical and Nutritional Management Team (PNMT) had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. In addition to the need for further follow-up on systemic issues previously identified, PNMT meeting minutes should include reports on the status of individuals' clinical health indicators, to assess whether individuals are better or worse, and to analyze the efficacy of their interventions.
- Some individuals in Sample 0.1, who met the PNMT referral criteria and should have been referred to the PNMT, were not.
- PNMT assessments continued to contain the majority of components necessary. However, additional work was needed to establish and/or review individual-specific clinical baseline data and to develop measurable outcomes related to individual-specific clinical indicators to assist teams in recognizing changes in health status and provide a methodology to measure whether or not the supports were effective. In addition, individuals' PNMT assessment recommendations had not been integrated into IHCPs.
- Individuals' Physical and Nutritional Management Plans (PNMPs) did not include all of the necessary components. Interdisciplinary Teams (IDTs) were reviewing individuals' PNMPs at the annual meetings, but the ISPs did not include evidence of the teams' review of PNMP effectiveness as well as accuracy, updates/revisions agreed upon by the teams, and specified changes required with rationale. On a positive note, the Facility continued to implement a process that alerted staff to PNMP revisions and their responsibility in the implementation of an individual's PNMP when revisions had been made.

- During the Monitoring Team's onsite review, a member of the Monitoring Team, PNMT Occupational Therapist (OT), Facility therapists, PNMP Coordinators, the Director of Residential Services, and the Unit Director for Ribbonfish completed mealtime and snack observations in Coral Sea and Ribbonfish. These observations occurred in dining rooms during lunch and/or dinner as well as an activity room where snacks were being presented. Multiple concerns were noted during these observations, which are discussed with regard to Section O.4.
- On a positive note, an observation of dinner in the Coral Sea dining room did not reveal any mealtime errors. For example, individuals were being brought to eat in different waves so that the dining room was not noisy and chaotic. Table captains did not leave the table during the mealtime. Staff were referring to the dining plans and were following the written instructions. This mealtime observation was similar to the mealtime observation that was completed at Coral Sea during the last review.
- The PNMT OT, Facility therapists, and two PNMP Coordinators completed observations of the implementation of PNMPs with a member of the Monitoring Team. Observations were completed in the Infirmary, the residences of Coral Sea and Ribbonfish, and day programs. These observations confirmed that staff continued to breach individuals' PNMPs.
- The Facility was providing physical and nutritional management (PNM) foundational training during New Employee Orientation (NEO) and annual refresher training. Individual-specific training was being provided to staff supporting individuals with needs beyond what the foundational training covered. However, the Monitoring Team was not able to discern from the documentation submitted if all required staff had successfully completed performance check-offs for individuals whose PNMP strategies required individual-specific training.
- Individuals in Sample O.1 and O.2 were not monitored for the effectiveness of their progress in relation to their physical and nutritional management needs, nor did the Facility provide evidence that interventions were modified if an individual was not making progress. More specifically, the implementation of individuals' IHCPs did not generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. Monthly progress notes were not completed to report on the effectiveness of individuals' supports and services, individuals' PNMPs and aspiration trigger data sheets did not have individual-specific triggers identified, and aspiration pneumonia trigger data sheets were not completed as required on a daily basis.
- The Facility maintained an updated list of individuals who received enteral nutrition. Individuals in the sample, who received enteral nutrition, were reviewed by their IDTs. However, the annual assessment did not include necessary elements.

<u>Physical and Occupational Therapy</u>

- Three individuals who were recently admitted to the Facility had Occupational Therapy/Physical Therapy (OT/PT) assessments completed within 30 days of admission. Some individuals' OT/PT assessments were not completed at least 10 days prior to the annual ISP and were missing important assessment elements.

Individuals who had experienced a change in status did not have assessment updates and/or consultations completed.

- Individuals receiving direct OT and/or PT interventions did not have plans implemented within 30 days of the plans creation and comprehensive monthly progress notes had not been completed. OT/PT assessment recommendations and/or recommendations for SAPs had not been integrated into individuals' ISPs.
- The Facility had developed the foundation of a sustainable system to monitor the condition, availability, and effectiveness of individual's prescribed equipment. However, the Facility did not have an adequate monitoring system for PNMPs, because the primary focus was meal monitoring.

Dental Services

- The Dental Department had been able to maintain a low percentage of individuals with poor oral hygiene. The annual summaries were complete and provided valuable information to the IDTs and to the community for those that were transitioning. Annual summaries were available for incorporation into the ISP process in a timely manner. There remained a low rate of edentulous individuals. There was also a low rate of need for oral sedation and intravenous (IV) sedation. There were numerous databases that were of high quality and appeared complete. The Dental Department had created new clinical indicators, focusing on the impact/outcome on the individual, such as the amount of new tooth decay, the degree of periodontitis, etc. This had the potential to provide a measure of whether the Dental Department was accomplishing its goals for the various services provided.
- Challenges did remain, but were focused on a few areas. There were a few desensitization plans in place with evidence of data collection showing progress might be occurring. However, these plans had only been finalized and implemented for a small number of the population eligible for such plans. The Dental Department also determined the need to reduce the number of refused appointments. This will require interdepartmental cooperation to achieve.

Communication

- The Facility had established a procedure that memorialized the process for determining Speech Language Pathologist (SLP) assignments and responsibilities. There were an adequate number of SLPs with specialized training or experience demonstrating competence in augmentative and alternative communication to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.
- Individuals who had been newly admitted to CCSSLC had a SLP screening and/or assessment completed within 30 days, Speech Language (SL)/communication assessments included necessary components, and SLPs and Psychologists/Behavioral Health Specialists were collaborating in the development of individual-specific communication strategies for behavioral support/interventions.
- It was very positive that observations of individuals with AAC devices showed individuals had their equipment and were using it, with staff assistance as necessary.

- ISPs generally provided some description of individuals' communication skills. However, additional work was needed to include descriptions of individuals' alternative and augmentative communication (AAC) systems and strategies for their use, as well as communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives.
- Individual-specific training and performance check-offs had been developed and implemented. However, the Facility had not finalized a process to identify the total number of staff who required individual-specific training and the total number of staff who had successfully completed competency-based performance check-offs.
- The Facility had policies/procedures that incorporated the elements necessary for monitoring communication supports. Individuals with AAC systems had not been monitored on a consistent basis using the Monthly Person-Specific PNMP Check Sheet. Since the last review, the completion of Communication Monitoring had significantly improved. However, a review of individual-specific monitoring forms indicated multiple areas of staff noncompliance. The Facility Self-Assessment stated: "this provision is not in compliance but is improving greatly." The Monitoring Team agreed with this statement.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>

- The Facility was providing ongoing review of the quality of habilitation assessments through its Assessment Review Committee. Ongoing feedback also was provided on the quality of skill training programs through the Skill Acquisition Review Committee. Both of these committees included interdisciplinary members who provided comprehensive and thoughtful feedback during document review.
- Integrated Monthly Reviews provided a cumulative review of progress to allow for timely revision of programs as necessary.
- The Facility was also making good efforts to expand the variety of programming available to individuals, particularly in the area of vocational services. A greater number of individuals were leaving their homes to participate in day programs for some portion of the week. On campus shuttle bus service had improved individuals' abilities to get to and from their scheduled activities. Staff schedules also had been varied to expand active treatment and supports to evening hours and weekends.
- Although the Facility had in place many very positive strategies to ensure adequate habilitation and educational services to the individuals served, the Facility remained out of compliance with all subsections of Section S. For example, although improvement was noted, problems continued to exist with skill acquisition programs (SAPs), such as the absence of behavioral objectives, limited teaching trials, and teaching conditions that did not provide clear and comprehensive instructions. Engagement continued to be low in residences and classrooms and day programs. Assessments such as Preference and Strength Inventories and Functional Skills Assessments continued to lack necessary information and/or summary/analysis, and as a result were of limited usefulness to teams responsible for developing habilitation plans for individuals. Community training opportunities continued to be limited.

Most Integrated Setting

- Systemic issues negatively impacted referrals and had not been addressed, including, for example:
  - Gaps or perceived gaps in supports in the community for individuals with complex behavioral and/or medical and physical and nutritional management needs;
  - For some individuals, a factor delaying referrals were the institutional practices, such as different traffic rules, on the campus that allowed individuals to become accustomed to a different set of expectations than are found in typical communities. Based on these institutional practices, teams concluded that the Facility was the "least restrictive alternative" for the individuals; and
  - For some individuals, teams had historically failed to educate them about options, and now concluded that because the individuals did not understand the options available to them and/or teams did not know their preferences, they should not be referred for community transition.
- At the Facility-level, teams continued to not fully identify or justify the obstacles to referral. In addition, although teams were developing action plans to address obstacles to referral, they were not individualized. The State Office's annual report on obstacles to referral and transition provided limited information about steps the State was taking on a systemic level to overcome obstacles, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.
- Although most assessments prepared for individuals' ISPs included recommendations related to their appropriateness for transition to the community, some assessments still did not include this information. In addition, although professional members of the team were making and documenting a joint recommendation in the ISP, sufficient justification for the recommendations often was not found, and/or reconciliation between the various team members' written recommendations was not documented.
- Community Living Discharge Plans continued to inadequately define the necessary protections, supports, and services to ensure the individual's health and safety, and limited progress had been made in this regard. Most of the issues identified in the Monitoring Team's previous reports regarding deficiencies with the CLDPs had not yet been rectified. As a result, individuals transitioning to the community were potentially at risk due to the lack of adequately planned and implemented protections, services, and supports.
- Post-move monitoring had been completed in a timely manner for all of the individuals who had transitioned to the community. Some concerns were noted with regard to the thoroughness of the post-move monitoring activities to confirm the provision of pre- and post-move supports, and substantiate the findings (e.g., interviews, document reviews and observations). In addition, concerns were noted with regard to the involvement of IDTs in the Facility's efforts to take reasonable action to correct deficiencies noted.

Consent

- As has been stated in previous reports, until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires. During this most recent review, Facility staff indicated that State Office had issued a draft Individual

Rights Assessment that included questions related to an individual's capacity to make decisions. Since the onsite review, the Monitors have jointly provided comments to State Office on the draft Individual Rights Assessment.

- The Facility continued to pursue some alternatives to guardianship, but this was an area in which more work was needed. For example, teams had identified approximately 13 individuals that would benefit from an advocate, and efforts continued to identify volunteer advocates. The Self-Advocacy Group engaged in activities that provided opportunities for participants to learn about their rights.
- As noted in past reports, CCSSLC continued to make efforts to identify potential guardianship resources. For example, a brochure had been developed and was being distributed in various forums, a relationship with a local university resulted in posting of volunteer opportunities on a listserv, and information about the need for volunteers to act as advocates or guardians was distributed at a booth at the Provider Fair. So far, limited, if any, resources for guardians had been identified. It will be essential that adequate resources be identified to address this need.

<u>Recordkeeping and General Plan Implementation</u>

- CCSSLC continued to maintain Active Records, as well as Individual Notebooks, and Master Records. The quality of the records was an area still in need of attention. Since the last review, the Unified Records Coordinator position was vacated, so the Facility was rebuilding its system related to conducting regular record reviews. The Facility recognized that next steps included analyzing the data, and developing and implementing plans to correct any issues identified.
- Since the last review, the Facility had developed and implemented an I-Learn course on Policy Creation, Maintenance, and Training. It provided good information in an interesting format, and included some quizzes to ensure staff's understanding. At the time of the last review, a method was being developed to accurately track staff's training on policies. At the time of this most recent review, the Competency Training Department had a process to for tracking the completion of training, and was able to send reminders to staff who had not yet completed the training. The Administrative Programs Specialist also assisted with training follow-up, and reported the training status to the QA/QI Council. However, it remained unclear whether staff were trained on State Office policies, and whether local policies had been developed or updated to correspond with State Office policies.

VI. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance:
▪ Review of Following Documents:
o Procedure C.8: Protection From Harm – Restraints, dated 5/3/13;
o Procedure C.5: Licensed Health Care Professional Responsibilities, dated 8/9/10;
o Restraint Checklist Competency Exam, undated;
o Policy: Use of Restraint, approved April 2012, updated 10/15/12;
o Section C Monitoring Tool, undated;
o Restrictive Practices Committee Minutes, from 9/11/13 through 3/21/14;
o CCSSLC Delinquent Level of Supervision Report, dated 4/3/14;
o List of Restraint Monitors, undated;
o List of Nurse Monitors trained to evaluate restraints, undated;
o Quality Assurance/Quality Improvement (QA/QI) Council Meeting Minutes, from 8/1/13 through 1/30/14;
o Presentation Book for Section C;
o Facility Self-Assessment, dated 3/14/14;
o Facility Action Plans: Section C, dated 2/3/14;
o CCSSLC: Do Not Restrain List, dated 2/8/14;
o CCSSLC: Individuals with Crisis Intervention Plans, dated 2/18/14;
o CCSSLC Combined Data Report, Representing Data for 12 months-date range from 2/1/13 through 1/31/14;
o Sample C1: Chosen from list individuals restrained between 9/1/13 and 2/28/14 per II.7 of document request. The list included 115 incidents of crisis restraint. A sample of 17 (15%) of the restraint episodes was drawn, including the following documents:
• The Restraint Checklist;
• The face to face/debriefing report;
• The crisis intervention plan;
• The Positive Behavior Support Plan;
• Any/all reviews of this use of restraint (Including Unit Team, Incident Management Team, Restraint Reduction Committee); and
• The ISP;
<table>
<tr><th>Sample #</th><th>Individual #</th><th>Date and time</th><th>Type</th></tr>
<tr><td>C1.1</td><td>Individual #191</td><td>2/6/14 at 11:00 a.m.</td><td>Physical</td></tr>
<tr><td>C1.2</td><td>Individual #348</td><td>10/21/13 at 1:23 p.m.</td><td>Physical</td></tr>
<tr><td>C1.3</td><td>Individual #348</td><td>12/6/13 at 7:19 p.m.</td><td>Physical</td></tr>
<tr><td>C1.4</td><td>Individual #348</td><td>12/6/13 at 6:36 p.m.</td><td>Physical</td></tr>
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</table>

C1.5	Individual #348	12/6/13 at 6:13 p.m.	Physical
C1.6	Individual #348	1/13/14 at 5:01 p.m.	Physical
C1.7	Individual #40	11/10/13 at 7:52 p.m.	Physical
C1.8	Individual #40	11/10/13 at 7:12 p.m.	Physical
C1.9	Individual #40	11/10/13 at 7:40 p.m.	Physical
C1.10	Individual #40	11/10/13 at 7:24 p.m.	Physical
C1.11	Individual #169	9/2/13 at 3:20 p.m.	Physical
C1.12	Individual #312	9/7/13 at 5:08 a.m.	Physical
C1.13	Individual #312	9/7/13 at 5:17 a.m.	Physical
C1.14	Individual #5	2/23/14 at 9:06 a.m.	Physical
C1.15	Individual #5	2/23/14 at 10:09 a.m.	Chemical
C1.16	Individual #27	11/30/13 at 8:00 a.m.	Chemical
C1.17	Individual #237	12/6/13 at 1:25 p.m.	Chemical

- **Subsample of C.1:** A subsample of three records from #C.1 for use in Section C.4.e and f. Documents included:
  - Medical Summary Active Problems list;
  - The form used by the Facility to document restraint considerations/restrictions; and
  - ISPs/ISPAs indicating that restraint considerations that have been identified by any member of the IDT have been addressed and documented.

Sample #	Individual #	Date and time	Type
C1.1	Individual #191	2/6/14 at 11:00 a.m.	Physical
C1.8	Individual #40	11/10/13 at 7:12 p.m.	Physical
C1.14	Individual #5	2/23/14 at9:06 a.m.	Physical

- **Sample #C.2**: The following documentation was requested for a selected sample of 22 staff:
  - Their start dates;
  - Their training transcripts showing date of most recent:
    - PMAB training;
    - Training on use of restraints; and
    - Training on abuse/neglect/exploitation;
- **Sample #C.3**: was chosen from the list provided in response to document request II.7b of 53 restraint reports for medical and dental restraint involving 19 individuals. The sample of 10 restraint reports (19% of the restraint episodes) was drawn representing five individuals or 26% of the individuals restrained. The documents included:
  - The restraint checklist;
  - Documentation of the monitoring of the restraint;
  - Any reviews of the use of restraint;
  - Any desensitization plan or other plan to reduce the use of restraint that may apply;
  - The physician's order for the restraint, including the monitoring schedule to be used; and

- The medical restraint plan.

Sample #	Individual #	Date	Type
C3.1	Individual #141	9/24/13 at 5:05 a.m.	Chemical
C3.2	Individual #141	10/14/13 at 9:15 a.m.	Chemical
C3.3	Individual #141	1/3/14 at 1:15 p.m.	Chemical
C3.4	Individual #147	11/22/13 at 8:30 a.m.	Chemical
C3.5	Individual #147	1/15/14 at 1:30 p.m.	Chemical
C3.6	Individual #147	1/22/14 at 5:40 p.m.	Mechanical
C3.7	Individual #198	10/29/13 at 9:00 a.m.	Chemical
C3.8	Individual #198	1/9/14 at 4:54 p.m.	Chemical
C3.9	Individual #224	10/17/13 at 8:30 a.m.	Chemical
C3.10	Individual #224	12/17/13 at 12:35 p.m.	Chemical
C3.11	Individual #311	11/15/13 at 10:15 a.m.	Chemical
C3.12	Individual #311	1/17/14 at 7:30 a.m.	Chemical

- **Sample #C.4: Chemical Restraints for Crisis Intervention Sample**: Sample Chosen from the list provided in II.7a in response to the document request. The total chemical restraints for crisis intervention was 17 Sample size was three, or 18%

Sample Identification #	Individual #	Date and Time	Type
C1.15	Individual #5	2/23/14 at 10:09 a.m.	Chemical
C1.16	Individual #27	11/30/13 at 8:00 a.m.	Chemical
C1.17	Individual #237	12/6/13 at 1:25 p.m.	Chemical

- **Sample #C.5**: There were two off-grounds restraints during the review period;

Sample Identification #	Individual #	Date and Time	Type
C5.1	Individual #253	9/2/13 at 3:42 p.m.	Physical
C5.2*	Individual #191	1/21/14	Mechanical

*This restraint was applied at the hospital under the direction of hospital personnel and assisted by the direct support professional assigned to the individual. Since it was not applied at the direction of CCSSLC personnel and the individual did not return immediately to CCSSLC, the IMRT correctly decided this did not pertain to Facility practice and did not complete the usual restraint forms. However, the Facility should review its practice with regard to direct support staff assisting hospital personnel with restraints for the protection of both the individual and the staff involved.

- Presentation at the entrance meeting;
- **For Section C.4:**
  - Dental Desensitization Plan for: Individual #58, Individual #372, Individual #119, Individual

#67, Individual #273, Individual #106, and Individual #3;
- Individual Support Plan for: Individual #297, Individual #58, Individual #298, Individual #296, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #333, Individual #237, Individual #359, Individual #77, Individual #191, and Individual #141;
- Integrated Risk Rating Form and Integrated Health Care Plan for: Individual #297, Individual #58, Individual #298, Individual #296, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #333, Individual #237, Individual #359, Individual #77, Individual #191, and Individual #141;

- **Sample C.6:**
  - List of restraints, from 8/1/13 to 2/28/14;
  - Description of Restraint Reduction Board, dated 2/13/14;
  - Minutes from Restraint Review Board meeting, dated 2/6/14;
  - Crisis Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing Form, and where appropriate, Administration of Chemical Restraint: Consult and Review for the following restraints:

Individual	Date of Restraint	Time of Restraint
Individual #40	10/7/13	8:21 p.m.
		8:39 p.m.
		8:54 p.m.
		8:57 p.m.
		9:01 p.m.
	11/10/13	7:12 p.m.
		7:24 p.m.
		7:40 p.m.
		7:52 p.m.
	12/10/13	6:12 p.m.
		6:33 p.m.
		7:14 p.m.
		7:31 p.m.
		7:32 p.m.
		8:10 p.m.
		8:31 p.m.
Individual #253	8/1/13	3:56 p.m.*
		4:12 p.m.*
		4:14 p.m.*
		4:27 p.m.*
		4:35 p.m.*
		4:48 p.m.*

		5:08 p.m.
		5:15 p.m.
		6:10 p.m.
		6:18 p.m.

*The Crisis Intervention Face to Face Assessment and Debriefing Form was not provided for these restraints.

- Individual Support Plans for: Individual #40 and Individual #253;
- Comprehensive Psychological Assessment for: Individual #40 and Individual #253;
- Positive Behavior Support Plan: Individual #40 and Individual #253;
- Individual Support Plan Addenda minutes for: Individual #40 and Individual #253;
- Positive Behavior Support Plan Progress Notes for: Individual #40 (9/13 to 1/14) and Individual #253 (7/13 to 9/13);
- Crisis Intervention Plan for: Individual #40 and Individual #253;

- **Sample #C.7**: chosen from the list of Protective Mechanical Restraints, dated 3/3/14, and submitted in response to Document Request 11.7. The documents included:
  - Restraint Checklist;
  - Face-to-face/debriefing report;
  - Documentation of monitoring of the restraint;
  - Order for the restraint and any alternate schedule of monitoring;
  - ISP confirming the use of the restraint; and
  - Any and all reviews of the use of the restraint.

Sample identification #	Name	Date	Type
C7.1	Individual #9	1/10/14 at 6:00 a.m.	PMR-SIB
C7.2	Individual #9	1/31/14 at 6:00 a.m.	PMR-SIB
C7.3	Individual #58	12/8/13 at 6:00 a.m.	PMR-SIB

- List of Facility approved restraints with policy reference included;
- Nursing Restraint documentation from the Restraint Checklists, Interdisciplinary Progress Notes, and Client Injury Reports for the following individuals:
  - Individual #191 on 2/6/14 at 11:00 a.m.;
  - Individual #348 on 10/21/13 at 1:23 p.m., 12/6/13 at 6:13 p.m., 12/6/13 at 7:19 p.m., and 1/13/14 at 5:01 p.m.;
  - Individual #40 on 11/10/13 at 7:12 p.m., and 11/10/13 at 7:52 p.m.;
  - Individual #169 on 9/2/13 at 3:20 p.m.;
  - Individual #312 on 9/7/13 at 5:08 p.m.;
  - Individual #5 on 2/23/14 at 9:06 a.m.; and
  - Individual #253 on 9/2/13 at 3:42 p.m.

- **Interviews with**:
  - Mark Cazalas, Facility Director;
  - Brandon Riggins, Assistant Director of Programs;

	○ Carolyn Milton, Director of Behavioral Health Services; ○ Everett Bush, Behavior Analyst I; ○ Cynthia Velasquez, Director for Quality Assurance (QA); ○ Beverly Okin-Larkin, System Analyst; ○ Kristina Sheets, Director of Residential Services; ○ John Henley, Unit Director for Atlantic; ○ Michael Robinson, MSN, RN-BC, Chief Nurse Executive (CNE); ○ Colleen M. Gonzales, BSHS, Nurse Operations Officer (NOO); ○ Campus Administrators; ○ Restraint Monitors; ○ Program Compliance Monitors/QA Nurse; ○ Staff members from various residential locations; and ○ Individuals in various residential locations. ▪ **Observations of**: ○ QA/QI Council Meeting, on 4/3/14; ○ Restraint Reduction Committee, on 3/31/14; ○ Atlantic Unit Team Meeting, on 4/2/14; ○ Incident Management Review Team meeting, on 4/2/14; ○ Residences: #515, #516, #522A, #522B, #522C, #522D, and the Infirmary #503; and ○ Vocational/day programs: #512, #513, and #523
	Facility Self-Assessment: The CCSSLC Self-Assessment indicated the Facility was in substantial compliance with one (C.3) of the 14 provisions in Section C of the Settlement Agreement. The Monitoring Team found the same. In its Self-Assessment, dated 3/14/14, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, and interviews with staff: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment consisted of a template entitled: "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section C-Protection from Harm-Restraints, Revised July 2012." ▪ This monitoring/audit tool included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tool was consistent with the provision of the Settlement Agreement. ▪ The monitoring tools included some adequate methodologies, such as the review of documentation, interviews, and observations. ▪ The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. ▪ The monitoring/audit tools the Program Compliance Monitors (PCMs) used included instructions/guidelines, which were generally adequate to ensure consistency in monitoring. ▪ The following staff/positions appeared to be responsible for completing the audit tools: The Program Compliance

	Monitor from the Quality Assurance Department and a designated Psychologist V from the Behavioral Services Department worked collaboratively to conduct the audits. ▪ For Section C, no information was provided regarding inter-rater reliability. ▪ The Facility did not use other relevant data sources and/or key indicators/outcome measures in its self-assessment. For example, although restraint trend reports were being produced, data from the trend reports was not used in the self-assessment. ▪ The Facility consistently presented some of the data in a meaningful/useful way. More specifically, the Facility: o Generally presented findings consistently based on specific, measurable indicators rather than on overall composite scores; o Presented some data in charts and tables across six months to allow for easy comparisons; o Included comments and examples to explain differences or irregularities in data; and ▪ When the Facility data identified some areas in need of improvement, it did not provide a thorough analysis of the information, identifying, for example, potential causes for the issues, but did connect the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. ▪ Many of the notes in the "completion status" column in the Action Plans indicated "in process." To be useful, an indication of what "in process" meant was needed. For example: Action Step C.1.9 indicated that the Behavioral Health Services Department would be trained to ensure reliability checks were completed following every crisis intervention restraint. The start date was 3/1/13 and the end date was 3/31/14. The status column indicated "in process." If notations were made on the progress in implementing a step with a lengthy time frame, there would be some sense of whether the step was proceeding as planned or whether nothing had been done to move forward during the time period.
	Summary of Monitor's Assessment: The Facility had made progress in the management of the use of restraints, including: ▪ There was a new Director of Behavioral Health Services, who began work in March 2014. ▪ The use of restraints for crisis intervention appeared to be continuing to decline, but the methods for counting restraints had changed several times, and it was not clear whether the decline was a true decline or the result of those changes in counting method. While it was encouraging to see a decline in restraint use, the safety of individuals is of paramount importance and it is important that low restraint use is not achieved at the expense of individual safety. ▪ The dates of reviews by the Unit and the IMRT were being documented on the Restraint forms on a more regular basis. ▪ There had been a clarification of the nursing protocols that were used for monitoring medical restraints and anesthesia. ▪ The use of Protective Mechanical Restraint for Self-Injurious Behavior remained low. Some areas were identified that needed attention, including: ▪ Clarification was needed of where staff were to document information about the behavior prior to the behavior that caused a restraint and this information needed to be documented on a regular basis. ▪ The Facility should consider reducing the number of restraint monitors and enhancing their training on monitoring restraints and how to use the monitoring forms.

	▪ Unit Team and IMRT meetings that the Monitoring Team attended included some good discussion, but the minutes needed to reflect consideration of accuracy of the documents presented, whether the restraint was necessary given the situation, whether there was a need for the IDT to meet to address any issues, and whether there were any other recommendations that needed to be addressed. ▪ Key indicators of performance needed to be identified to track progress. ▪ When medical/dental restraints were used, the physician needed to specify the type and frequency of monitoring that was to be done, and then the monitoring needed to be carried out as ordered.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>The Facility provided the following data, based on information contained in trend reports:
<table>
<tr><th>Type of Restraint</th><th>3/1/13 to 8/31/13 (6 months)</th><th>9/1/13 to 2/28/14 (6 months)</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>118</td><td>88</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>11</td><td>11</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>11</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>140</td><td>99</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>27</td><td>19</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>7</td><td>5</td></tr>
<tr><td>Medical/dental restraints</td><td>98</td><td>118</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>42</td><td>40</td></tr>
<tr><td>TOTAL protective mechanical restraints for self-injurious behavior (PMR-SIB)</td><td>507</td><td>270</td></tr>
<tr><td>TOTAL individuals restrained per PMR-SIB</td><td>3</td><td>2</td></tr>
</table>
<u>Prone Restraint</u>
a. Based on Facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (trend reports and lists of restraints) prone restraint was not identified.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		A sample, referred to as Sample #C.1, was selected. (A list is provided in the Documents Reviewed Section above.) c. Based on a review of the 17 restraint records for individuals in Sample #C.1, none (0%) showed use of prone restraint. d. Based on questions with 10 direct support professionals, 100% were aware of the prohibition on prone restraint. <u>Other Restraint Requirements</u> e. Based on document review, the Facility and State policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ f. In 17 of the 17 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. ▪ g. For the 17 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 13 (76%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. The four that did not were sample #C1.2, #C1.6, #C1.12 and #C1.13. In each of these records there was no description of the events that led to the behavior that caused the restraint to be used. ▪ h. In 17 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. However, the information was provided via a checklist of interventions with no indications of effectiveness or the time during which the interventions were employed. When a PBSP was present, it was difficult to tell whether it had been employed as written without some description of the order in which the interventions were employed. As a result, while the basic information was in place, it was not useful in deciding how to modify training for staff, PBSPs or their implementation, or restraint procedures to be more effective. ▪ i. Facility policies did identify a list of approved restraints. ▪ j. Based on the review of 17 restraints, involving eight individuals, 17 (100%)	

#	Provision	Assessment of Status	Compliance
		were approved restraints. k. In 13 of these records (76%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Those that did not were the same as discussed with regard to C.1.g above, based on a lack of documentation of the events that led to the behavior. That documentation was needed to allow a determination if the PBSP had been followed, and whether there were measures that might have been taken to avert the behavior that led to restraint. If there were no events leading to the behavior that caused the restraint, it would be useful to know what was supposed to be going on at the time l. Of the restraints of two individuals that were considered to be PMR-SIB by the Facility, the Monitoring Team reviewed three (Sample C.7). Of these, none (0%) followed State Office policy regarding the use, management, and review of PMR-SIB. ▪ Samples #C7.1 and #C7.2: These restraints involved use of mittens to prevent self-injury for Individual #9. A plan was in place that included scheduled release; one-to-one staffing was provided; and a staff member, a nurse, a Behavior Health Specialist, and a restraint monitor documented review of the restraint each day. Application of the restraint was documented in the Restraint Checklist. However, it was not clear from the documentation that the releases and re-restraints occurred as prescribed in the plan. ▪ Sample #C7.3: involved use of an abdominal binder to prevent dislodgement of a g-tube. A plan was in place and the nurse, behavior specialist and restraint monitor made onsite observations as required. The restraint use was monitored and documented on the Restraint Checklist. However it was not clear from the documentation whether the releases were completed according to the plan. For example, the plan called for the restraint to be on while asleep until 7:00 a.m., then off from 7:00 to 9:15 a.m. for hygiene. However, there was no documentation at all until 11:00 a.m., when a circulation check was performed and the restraint was replaced. At the time of the review the Facility reported that it now had only one person using protective mechanical restraint. In spite of the issues with documentation, it appeared that the Facility was successful in fading the use of PMR-SIB and avoiding its use whenever possible. Based on this review, the Facility remained out of compliance with this provision due to the lack of descriptions of events prior to the behavior that led to restraint, and the lack of documentation of restraint application and release for individuals in PMR-SIB. While the Facility deserved recognition for having fading plans in place for individuals in PMR-SIB, and for reportedly keeping the use of protective mechanical restraints low, it remained	

#	Provision	Assessment of Status	Compliance
		necessary to assure that staff were documenting the application and release of restraints on the restraint checklists as indicated in the plans. The Facility had included a more recent example of a restraint checklist for Individual #9 with the restraint applications and releases more clearly documented, indicating that the Facility had recognized and had begun to improve documentation.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 14 restraint records involving the six individuals in Sample #C.1, who were physically restrained, were reviewed. Of these, one of the individuals had a Crisis Intervention Plan (CIP) that defined the use of restraint and five did not at the time of the restraint. In four of the 14 restraint records (samples #C1.9, #C1.11, #C1.12, and #C1.13), the restraint was ended when the restraint could not be maintained and these four records were eliminated from the sample. Of the ten restraints remaining: a. For one restraint involving one individual who had a CIP: in none of the restraints (0%) sufficient documentation was included to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. For those that did not: ▪ In Sample #C.1.1, the restraint was not held for the three minutes beyond reaching quiet, as required in the CIP. b. For nine restraints involving three individuals who did not have Crisis Intervention Plans, nine (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review, the Facility remained noncompliant due to the finding that Crisis Intervention Plans were not being followed as to release of restraint. The CIP release criteria should define when an individual is considered to be "no longer a danger to self or others." Because these criteria can be different from individual to individual, staff implementing restraints need to follow the instructions in the CIPs. Failure to implement the CIP release criteria could potentially result in a repeated restraint or multiple restraints, which places both the individual and staff at higher risk.	Noncompliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Sample #C.2 was selected from a current list of staff. A description of Sample #C.2 is provided in the Documents Reviewed section above. b. A sample of 24 current employees was randomly selected from a current list of staff. A review of the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: ▪ 21 of the 22 (95%) had current training in RES0105 Restraint Prevention and Rules. The exception was Employee #232288, who had been hired on 6/1/12 and been retrained on RES0105 on 2/10/14. Although the employee was current, there was nothing in the record to indicate if she had taken it by her anniversary date. As a result, there had potentially been a nine-month period in which the employee was not current with the training. ▪ 20 of the 22 (91%) had completed PMAB training during new employee training or refresher training within the past 12 months. The two that had not were: o Employee #195513 who was reported as delinquent in PMAB for not having taken the refresher training since 3/27/13. o Employee #232288 who had been hired on 6/1/12, and had been retrained on PMAB on 8/7/13 and 8/31/13. Both of the retraining dates were more than a year after her hire date. c. Based on responses to questions, 10 direct support professionals answered the following questions correctly: ▪ What policies govern the use of restraint (100%)?; ▪ Describe two verbal or redirection techniques (100%); ▪ Describe two approved restraint techniques (100%); and ▪ How would you supervise an individual in restraint (100%)? d. In 17 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Based on this review, the Facility was in substantial compliance with this provision.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be	a. Based on a review of 17 restraint records (Sample #C.1), in 17 (100%) there was evidence that documented that restraint was used as a crisis intervention. b. A sample of PBSPs were selected and reviewed to examine whether or not restraints were used for anything other than crisis intervention. Based on this review, there was no evidence that restraint was being used for anything other than crisis intervention. That is, there was no evidence in these records of the use of programmatic restraint. In	Noncompliance

#	Provision	Assessment of Status	Compliance
	used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	addition, as presented earlier and reported in the Monitoring Team's previous reports, the Facility policy did not allow for the use of restraint for reasons other than crisis intervention. c. In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention, except for protective mechanical restraints for self-injurious behavior. d. In 17 of 17 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list maintained by the Facility. Based on three records from Sample #C.1, listed under documents reviewed above as Subsample of #C.1: ▪ e. In three of three restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to a comparison of the Annual Medical Summary Active Problems list and the form used by the Facility to document restraint considerations/ restrictions. ▪ f. In three of three restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. The Facility reported that dental desensitization plans had been developed for 11 individuals. A review was conducted of seven of these plans. The findings are summarized below: ▪ All of the plans had been initiated or revised between 10/21/13 and 2/3/14. ▪ Four plans consisted of the individual tolerating a scaler or blunt instrument being placed in his/her mouth. The other plans focused on the individual tolerating having her teeth flossed, having his teeth scaled, or having his teeth brushed. ▪ Six of the seven plans provided an operational definition of the individual's behavior. The exception was the plan for Individual #273 in which the operational definition was a repetition of the behavioral objective. In four plans, tolerating or allowing the trial was defined as opening one's mouth and "allowing" staff to carry out the procedure. The plan for Individual #67 indicated she would "allow" the procedure. None of these plans clearly described the individual's behavior in observable or measurable terms beyond opening one's mouth. It would be helpful to know whether the individual was to demonstrate cooperation by sitting or lying still, by the absence of a struggle, etc. The plan for Individual #106 described his leaning back in the dental chair and opening his	

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		mouth. All other descriptors referenced his "allowing" different procedures. ▪ All of the plans were to be implemented at the dental clinic. ▪ Six of the seven plans were scheduled for implementation twice per week. The remaining plan was scheduled for implementation once per week. ▪ All of the plans listed a least to most prompting sequence. It should be noted that the gesture and partial physical prompts were described as showing the individual the materials used or having the individual touch the materials used, respectively. A full physical prompt was described as staff continuing to try completing the procedure. None of these are accurate descriptions of prompting strategies. Further, it is very unlikely that a full physical prompt would be used when implementing any dental procedure, because this would likely result in a form of restraint. ▪ In all of the plans, the consequence for correct responding was praise and some tangible reinforcer that would "vary according to what dental staff have." It is suggested that reinforcers should be identified based upon the individual's preference and should not be dependent upon what is available. ▪ A review was also completed of two to six months of data for these seven plans. o In four cases, it appeared that the individual had met the mastery criterion, but he/she had not advanced to the next step in the task analysis. For example, Individual #372 had completed 6 of 7 trials in February, clearly meeting the expectation of a 50% completion rate. She remained on the same step in March. Individual #119 met criteria after two months of training, but the step remained the same for two additional months. When the criterion was finally changed, it did not match the task analysis written in his plan. The same was true for Individual #67 and Individual #273. o Of particular concern was the February data for Individual #58. Notes written on the data sheet indicated that staff should be careful, because he was "violent" and would bite, hit, or kick. The data did suggest that he was being successful as seven of eight trials were completed. A request was made for the Facility's tracking of consent for all pretreatment sedation. The Facility provided a one-page response indicating that consents had been obtained, but a tracking system was not in place. It will be essential to keep track of this information to ensure that all required consents have been obtained and are current. The ISPs and IRRFs for 16 individuals were reviewed as discussed in further detail with regard to Section S.1. Team approval for pre-treatment sedation was noted in the rights restriction section of the ISP for eight of the 11 individuals (73%). Teams should ensure regular review and informed consent by the team whenever pretreatment sedation is employed for dental and/or medical procedures.	

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		In reviewing ISPs for nine individuals (i.e., Individual #58, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #333, Individual #77, and Individual #141) for whom restraint had been used for the completion of medical and/or dental work: • g. None (0%) showed that there had been appropriate authorization [i.e., Human Rights Committee (HRC) approval and adequate consent]; • h. Dental desensitization plans to minimize or eliminate the need for sedation and/or restraint had been developed for two of the nine individuals (22%). There was no evidence that desensitization plans had been developed to address the need for sedation and/or restraint for medical procedures; and • i. None (0%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. Although the Facility had initiated a review of all individuals regarding their need for pretreatment sedation for dental and/or medical work and their appropriateness for a dental desensitization plan, there remained very little evidence of comprehensive planning to address this very restrictive practice. For this reason, the Facility remained out of compliance with this provision of the Settlement Agreement. Based on this review, the Facility was not in compliance with this provision.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a	a. It was not clear that restraint monitors were being taught how to review the restraint checklists to assure they contained a clear description of the circumstances (i.e., prior events, application and consequences) of the restraint. As a result, review of the Facility training documentation showed there was not an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. A copy of the Restraint Checklist Competency Exam was provided. The copy was not dated, making it difficult to know when it had been adopted, and the answer guide was not provided, making it difficult to know the expectations for performance. In addition, it was not clear whether the exam was intended for direct support staff or for restraint monitors. If this exam was intended for Restraint Monitors, it did not cover the requirements for completing the Face-to-face assessment. As a result, it could not be determined in the training for restraint monitors was or was not competency-based. c. Based on review of the list of restraint monitors, 190 staff at the Facility who performed the duties of a restraint monitor had successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint.	Noncompliance

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	physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Based on a review of 17 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ d. In 13 out of 17 incidents of restraint (76%) by a trained staff member according to the list of Restraint Monitors provided. Records that did not contain documentation of this included: Sample #C1.2, Sample #C1.1, Sample #C1.13, and Sample #C1.14, where the name listed as Restraint Monitor did not appear on the list provided of trained Restraint Monitors. ▪ e. In 14 out of 17 instances (82%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Those that did not were samples #C1.8, #C1.9, and #C1.10, where the Restraint Monitor arrived from 15 to 45 minutes after the start of the restraint. ▪ f. In 16 instances (94%), the documentation showed that an assessment was completed of the application of the restraint. The one that did not was #C1.1 where the assessment did not indicate that the Crisis Intervention Plan had not been followed with regard to maintaining the restraint for three minutes beyond calm and quiet. While there was a Face-to-Face Assessment of the application of restraint in all records, there were inconsistencies in many of the records. Records that contained inconsistencies included: o For Samples #C1.2, #C1.3, #C1.4, #C1.5, #C1.6, #C1.12, and #C1.13, there was no information on the behaviors prior to the behavior that caused the restraint on the Restraint Checklist (though for #C1.3, #C1.4 and #C1.5 the information was included in the debriefing), yet the Face-to-face assessment indicated the Restraint Checklist was correct. The information about behaviors prior to should be entered on the section of the Restraint Checklist: "Description of Behaviors Prior to the restraint." The section "Reason for the Restraint" should contain the information about the behavior that caused the restraint. If there is not sufficient text space in that section, the behavior that caused the restraint could be included in the "Description of Behaviors Prior…" When the prior behavior information was found in the debriefing, this lack of information about prior behaviors in the Restraint Checklist did not affect the scoring of the metrics elsewhere in this report. o g. In 17 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint. There were no reported instances where a physician had ordered alternative monitoring of a restraint. If there had been, the following metrics would have been addressed. ▪ h. In ____ out of _____ (__-%), the extraordinary circumstances necessitating the alternative monitoring were documented; and ▪ i. In _____ out of ____ (____%), the alternative monitoring schedules were followed.	

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		Based on a review of 10 personal restraint records (i.e., physical holds) for six individuals for restraints that occurred at the Facility (i.e., Individual #191, Individual #348, Individual #40, Individual #169, Individual #312, and Individual #5), there was documentation that a licensed health care professional: ▪ j. Initiated monitoring at least every 30 minutes from the initiation of the restraint in eight (80%) of the instances of restraint. Records that did not contain documentation of this included: Individual #40 on 11/10/13 at 7:12 p.m., and Individual #169 on 9/2/13 at 3:20 p.m. ▪ k. Monitored and documented vital signs in 10 (100%) episodes. ▪ l. Monitored and documented mental status in 10 (100%) episodes. Based on documentation provided by the Facility, one restraint (Sample #C5.1) had occurred off the grounds of the Facility in the last six months. A sample of one was reviewed (Individual #253). A licensed health care professional: ▪ m. Conducted monitoring within 30 minutes of the individual's return to the Facility in one out of one (100%). ▪ n. Monitored and documented vital signs in one (100%). ▪ o. Monitored and documented mental status in one (100%). However, the Monitoring Team noted that the restraint in Sample #C1.16 was also an off-grounds restraint where an individual was administered a chemical restraint while at a hotel. The absence of that restraint from the off-grounds list, suggested the database needed to be checked for coding errors. Sample #C.3 was selected from the list the Facility provided of individuals who had medical restraint in the last six months. It represents 26% of the individuals for whom medical restraint was used. (Sample #C.3 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ p. In none out of 12 (0%), the physician specified the schedule of monitoring required or specified Facility policy regarding this was to be followed. ▪ q. In none out of 12 (0%), the physician specified the type of monitoring required if it was different than the Facility policy. ▪ r. In six out of 12 of the medical restraints (50%), appropriate monitoring was completed either as required by the Settlement Agreement, Facility policy, or as the physician prescribed. The six that were rated as completed were sample #C3.1, #C3.3, #C3.5, #C3.8, #C3.11, and #C3.12. In each case, although the physician's order did not specify the type or schedule of monitoring, the nursing protocol for monitoring medical restraints, as found on the nurse's keychain, was followed.	

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		The physician's order needs to specify the schedule and type of monitoring, or at least reference the nursing protocol. If policy made this an unnecessary step, that policy should be provided to the Monitoring Team. To verify that the nursing protocol was followed, it was necessary to review the monitoring as recorded on the Restraint Checklist. The checklist did not print out with the monitoring in the order that it occurred. This made it extremely difficult to verify that the monitoring occurred according to the protocol. Based on this review, the Facility was not in substantial compliance, because the curriculum and training for restraint monitors was not adequate in that it did not address how to assure accuracy and consistency in the documentation of restraints and did not have a clear method for measuring the competency of those receiving the training. In addition, staff who signed as Restraint Monitors were not always on the list of trained staff; nursing reviews of restraints had improved, but were not consistently timely; and there was no documentation that physicians had ordered schedules of monitoring or types of monitoring for medical restraints, although there was a Nursing Protocol that described the expected monitoring when chemicals were used for medical and dental restraints. If the expectation was that nurses would follow the protocol in the absence of other instruction, then that should have been made clear in policy.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an	A sample (Sample #C1) of 17 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ a. In the 16 for which it was applicable (100%), continuous one-to-one supervision was provided. In the one that did not, sample #C1.15, the restraint was chemical and an enhanced level of supervision was indicated, but not one-to-one supervision. ▪ b. In 17 (100%), the date and time restraint was begun; ▪ c. In 17 (100%), the location of the restraint; ▪ d. In 13 (76%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. Those that did not were Samples #C1.2, #C1.6, #C1.12 and #C1.13 (as discussed with regard to indicator C.1.g above). ▪ e. In 17 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per Section C.8. Each form contained a list of attempts to avoid restraint, but none provided the timeframe in which the attempts occurred or the effectiveness of any of the attempts. ▪ f. In 17 (100%), the specific reasons for the use of the restraint. ▪ g. In 17 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ h. In 17 (100%), the names of staff involved in the restraint episode;	Noncompliance

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	alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	▪ Observations of the individual and actions taken by staff while the individual was in restraint (only the 14 physical or mechanical restraints were considered), including: o i. In 14 (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration); o j. (Not applicable, since none of the 14 restraints lasted 15 minutes.) In (____%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; and o k. (Not applicable, since none of the 14 restraints lasted 30 minutes.) In ___ (____%), the care provided by staff during restraint lasting more than 30 minutes, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. ▪ l. In 14 (100%), the level of supervision provided during the restraint episode; and ▪ m. In 14 (100%), the date and time the individual was released from restraint. Based on a review of 11 restraint records for seven individuals for restraints that occurred at the Facility and one individual for a restraint that occurred off the Facility grounds (i.e., Individual #191, Individual #348, Individual #40, Individual #169, Individual #312, Individual #253, and Individual #5): ▪ n. In all 11 episodes (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects was appropriately documented. ▪ o. In a sample of records (Sample #C.1), restraint debriefing forms had been completed for 17 (100%). However, in four of those debriefing forms, no information had been gathered about the behavior prior to the behavior that caused the restraints. That information was not on the Restraint Checklists or on the Face-to-Face forms either (i.e., Sample #C1.2, #C1.6, #C1.12 and #C1.13). ▪ p. A sample of 12 individuals subject to medical restraint was reviewed (Sample #C.3), and in six (50%), there was evidence that the monitoring had been completed according to the applicable nursing protocol. As indicated with regard to Section C.5, physicians' orders did not specify monitoring. Sample #C4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last onsite review. This sample of three individuals who were the subject of a chemical restraint was reviewed. ▪ q. In three (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the	

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		Behavior Health Specialist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Based on this review, the Facility was not yet in substantial compliance due to the lack of physicians' orders for the types and schedules of monitoring for medical restraints, and while there was progress in documenting the events prior to the behavior that caused restraint, this was an area that required further attention.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to the Facility's documentation, between 8/1/13 and 2/28/14, crisis intervention restraint was utilized more than three times in a rolling 30-day period for six individuals. Two of these individuals were selected for review. For Individual #40 and Individual #253, four or more restraints in a 30-day period were identified and reviewed. Documents reviewed for these specific incidents included: Crisis Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Form, Administration of Chemical Restraint: Consult and Review, Individual Support Plan, Comprehensive Psychological Assessment, Positive Behavior Support Plan, Crisis Intervention Plan, ISP Addenda, and Positive Behavior Support Plan Progress Note. It should be noted that the Crisis Intervention Face-to-Face Assessment and Debriefing Forms completed for each of the restraints conducted within the same day with Individual #40 were identical. Staff should provide information specific to the restraint that is under review. For one of the four instances (25%) of more than three restraints in 30 days, the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. The following is an example where teams met and utilized the Individual Support Plan addendum to guide the discussion: ▪ The team for Individual #40 met on 12/13/13 in response to eight restraints that had occurred on 12/10/13. For three of the four instances (75%) of more than three restraints in 30 days, the team failed to meet within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. However, the team did meet within 11 to 22 business days to review these repeated restraints. This is summarized below: ▪ The team for Individual #40 met on 10/25/13 to review five restraints that had	Noncompliance

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		occurred on 10/7/13. His team met again on 11/26/13 to review four restraints that had occurred on 11/10/13. ▪ The team for Individual #253 met on 9/3/13 to review 10 restraints that had occurred on 8/1/13. When the individuals' teams met to discuss repeated restraint, it was evident that a discussion had taken place regarding the individual's adaptive skills, as well as biological, medical, and psychosocial factors. For two individuals (100%) there was evidence that the team hypothesized that one or more factors affected the behavior that resulted in restraint. Recommended action plans were identified in each case. However, as discussed below, it was not clear that for Individual #253 the team had identified all relevant issues (i.e., unstructured times around mealtimes). Examples included the following: ▪ After reviewing the restraints that occurred on 12/10/13, the team agreed that what initially upset Individual #40 was his inability to have the same food at dinner that his peers were eating. He also responded negatively earlier in the day at lunch, but was able to accept the rationale provided by staff. The team quickly reviewed his current health status and agreed that he could again receive a regular diet. This change was completed within two days. ▪ The team for this same individual also reviewed information from his most recent speech and language evaluation. It was noted that he could become frustrated when his spoken language was not understood. A communication book was to be developed. It was not clear if this communication book was available to him prior to the incidents of restraint. ▪ The team for Individual #253 noted that she often displayed aggressive and self-injurious behavior following a visit with her family. The action plan developed to address the difficulty experienced by Individual #253 was neither comprehensive nor appropriate. The team agreed that a contract would be developed with her guardian. Following a visit with her family, Individual #253 would have to engage in zero rates of aggression and/or self-injury for one month. If she met this criterion, she would then have a second visit with her family. There was no description of what was to occur if she failed to meet this criterion. What was more disturbing was that there were no guidelines developed to address the supports that could be offered to her upon her return to the Facility following a family visit. As described in several documents, she clearly was sad to return to the Facility and expressed missing her family. She also was noted to be more likely to engage in problem behavior before and after meals and when there was unstructured time. It would be advisable for the team to focus on preventing aggressive and self-injurious behavior by developing a schedule of interesting and varied activities upon her return from a family visit to ensure that she is engaged in preferred activities, among other antecedent	

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		strategies. The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need for timely reviews of more than three restraints in a 30-day period, a comprehensive analysis of adaptive skills, along with biological, medical, and psychosocial factors is required. In addition, when teams conduct analysis of adaptive skills and identify issues, then teams need to act to address the issues identified.	
	(b) review possibly contributing environmental conditions;	For one of the four instances of more than three restraints in 30 days (25%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. Meetings occurred between 11 and 22 days following more than three restraints in 30 days for the three other instances (75%). When the individuals' teams met to discuss repeated restraint, it was evident that a discussion had taken place regarding environmental conditions. For two individuals (50%), there was evidence that the team discussed fully the possibly contributing environmental conditions that affected the behavior that resulted in restraint. Examples of where teams made some attempt to discuss these factors included the following: ▪ The team for Individual #40 noted that he had recently moved to a new home. It was hypothesized that he held a grudge against a peer who was living in his former home. A negative interaction had occurred the week before the restraints. ▪ The team for Individual #253 reviewed her dislike of noisy and crowded environments, but this was not the situation at the time of her restraints. The teams for both individuals failed to discuss issues related to the reported problems associated with unstructured or down time. This was identified as a setting event for both Individual #40 and Individual #253. The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need for timely reviews of more than three restraints in a 30-day period, teams needed to conduct a comprehensive analysis of environmental variables.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For one of the four instances of more than three restraints in 30 days (25%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. Meetings occurred between 11 and 22 days following more than three restraints in 30 days for the three other instances (75%). For both individuals (100%), there was evidence of discussion of potential environmental and psychosocial antecedents to problem behaviors that may lead to restraint. Information included in the Comprehensive Psychological Assessment for Individual #40	Noncompliance

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		and Individual #253 reflected a Structural and Functional Assessment completed within six and five months, respectively. Both indirect and descriptive assessments were completed. The team for Individual #40 had quickly taken action to change his diet to allow him to eat the same foods as his peers. This was an appropriate and simple change that could be implemented quickly. Although the team for Individual #253 had discussed her difficulty returning from a visit with her family, the plan was not appropriate or ethical as it would result in preventing her from a second visit with her family should she display problem behaviors. There were no antecedent strategies identified to help improve her transition back to the Facility following a family visit. It was also noted that this individual had difficulty responding to peers who were rude to her. In summary, for these two individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in both of the cases (100%). Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in one of the cases (50%). For the two individuals in the sample, the Facility had completed structural assessments within the past year. However, teams did not meet to review these assessments in a timely manner, and did not consistently make the necessary changes when the need was identified. The Facility was found to remain in noncompliance with this provision of the Settlement Agreement.	
	(d) review or perform functional assessments of the behavior provoking restraints;	For one of the four instances of more than three restraints in 30 days (25%), there was evidence that the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. Meetings occurred between 11 and 22 days following more than three restraints in 30 days for the three other instances (75%). For both individuals (100%), there was evidence of discussion of consequences that were likely maintaining the problem behaviors that resulted in restraint. Replacement behaviors had been identified to serve the same hypothesized function as the identified problem behaviors. Information included in the Comprehensive Psychological Assessment for Individual #40 and Individual #253 reflected a Structural and Functional Assessment completed within six and five months, respectively. Both indirect and descriptive assessments were completed. For the two individuals in the sample, the Facility had completed functional assessments within the past year. However, teams were not meeting timely to review more than three	Noncompliance

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		restraints in 30 days. The Facility was found to be in noncompliance with this provision of the Settlement Agreement.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	The two individuals reviewed (100%) had a Positive Behavior Support Plan (PBSP) in place at the time of repeated restraint. The PBSP for Individual #253 that was provided to the Monitoring Team was implemented following the repeated restraint, however, it appeared that the only change that had been made from the previous PBSP was the identification of two additional replacement behaviors. The review of these PBSPs is summarized below: ▪ In the PBSPs provided for both individuals (100%), there was evidence of operationally defined problem behaviors. It was concerning that self-injury was identified as a behavior to be monitored for Individual #40, because when he displayed this behavior he could cause serious harm to himself. ▪ In the PBSPs for two of individuals (100%), there was evidence of at least one functionally equivalent and operationally defined replacement behavior. o Individual #40 was learning to ask for desired items. If he could not have the requested item, staff were to propose an alternative. Praise was to be offered when he practiced this behavior. As access to items is a proposed function of his problem behavior, it is suggested that a more powerful reinforcer should be applied when he tolerates a denial to his request. It was unclear how the second replacement behavior provided him with access to attention. He was to be offered two alternative activities to choose from when a preferred activity was not available. o Individual #253 was learning to ask for attention, ask for items, and ask for a break. These were all clearly defined. ▪ In the PBSPs for two individuals (0%), there was evidence of sufficient programs designed to reduce or eliminate the problem behaviors that led to restraint. o Individual #40 was to be encouraged to attend to his daily programming and participate in activities. A more structured plan was needed, including a dense schedule of reinforcement, to address his refusal to participate. o Individual #253 was to be reminded that she could take a break whenever the environment became too noisy or crowded. She was also to be directed to a quiet area and engaged in a preferred activity when a housemate was having difficulty. Again, more structured reinforcement was needed. Neither plan (0%) included a dense schedule of reinforcement to strengthen appropriate behavior or help eliminate identified problem behaviors. ▪ In the PBSPs for two individuals (0%), there were clearly specified interventions designed to reduce or eliminate at least one of the behaviors that led to restraint. If Individual #40 picked up an item to use as a weapon, staff were to use "PMAB	Noncompliance

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		communication skills." These skills should have been clearly described in the PBSP. The PBSP for Individual #253 did not provide clear guidelines for managing her self-injurious behavior. Staff were advised to use "PMAB skills," but the specific skills were not identified. Both of the individuals in the sample had a Crisis Intervention Plan. A summary of the review of these plans is provided below: ▪ A hierarchy of protective holds was described with a progression from least to most intrusive: hand over hand, standing basket hold, and basket hold follow down. Staff were to increase the level of intrusiveness if each preceding hold was "not sufficient." Staff should describe, in observable and measurable terms, the individual's behavior that would necessitate a more intrusive hold. ▪ The maximum duration of the restraint prior to an attempted release was 15 minutes. ▪ The observed behaviors that constituted a crisis situation were described. The CIP for Individual #253 noted that a crisis occurred when her self-injurious and/or aggressive behavior could not be verbally or physically redirected. The CIP for Individual #40 indicated a crisis situation was when he displayed aggression and there was a possibility of causing injury to himself or others. The team should review this with all staff to ensure that there is a real distinction between aggression that can be addressed by following his PBSP versus aggression that results in restraint. ▪ The criterion for release from restraint was identified in both plans. Individual #40 was to be quiet (i.e., no screaming, struggling, or swinging) for one minute and Individual #253 was to be released when she was not struggling, yelling or cursing, or trying to hurt herself for two minutes. It is suggested that there should be clear guidelines for staff to follow when monitoring for these release behaviors. It would be possible for the individual to meet the criterion for most of the required time, but then yell for 10 seconds. This could result in continued restraint. Administrative review might be required at some point in the restraint to ensure that the hold is not unnecessarily prolonged. o Of concern were the notes included in the Crisis Intervention Face-to-Face Assessment and Debriefing Forms from restraints applied on 11/10/13 for Individual #40. It was reported that staff were to be trained on his CIP that specified he would be released following two minutes of calm behavior. Although this change was proposed at the ISPA held on 12/13/13, this criterion was not noted in the approved CIP. ▪ It should be noted that the Facility reported that the CIP for Individual #40 was not in place for the restraints that occurred on 10/7/13 and 11/10/13. However, the CIP provided to the Monitoring Team reflected approval by the Behavior Support Committee on 4/23/13. Unless it took over five months to	

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		receive the approval of the guardian and the Human Rights Committee, this plan should have been implemented in a more timely manner. Further concerns were raised when reviewing the ISPAs. At a meeting held on 10/25/13, it was noted that all staff would be trained on the CIP by 11/15/13. At the meeting held on 11/26/13, the completion date for this training was changed to 12/6/13. Training should have been a priority. The Facility remained out of compliance with this provision of the Settlement Agreement. Positive Behavior Support Plans will need to identify strategies to address all targeted problem behaviors including comprehensive prevention strategies, functionally equivalent replacement behaviors with adequate training guidelines, enriched schedules of reinforcement for appropriate behavior, and specified consequences. Crisis Intervention Plans should be developed in response to repeated restraints and should clearly outline behavioral crises with clear and appropriate guidelines for release.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	As reported by the Facility, there was no assessment of treatment integrity for Individual #40 during the period of repeated restraints. The ISPA for Individual #253 noted that a "reliability score following a restraint on 7/2/13 indicated a score of 100%." As there was no description of what occurred, it was not clear that this was an assessment of treatment integrity or PBSP implementation as a staff member worked with the individual. The Facility remained out of compliance with this provision of the Settlement Agreement. It will be necessary to develop a system for regular assessment of plan implementation with a high degree of treatment integrity.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	As noted above, each of the two individuals in the sample had a PBSP in place at the time of repeated restraint. Specific dates of review and/or revision are addressed below: ▪ The PBSP for Individual #40 did not include dates of revision, approval, or implementation. However, the plan was signed on 9/30/13. Of concern was the lack of guidelines for staff to follow when this young man exhibited self-injury. This was a monitored behavior, and therefore, there were not antecedent or consequent strategies listed. As defined, this behavior could result in significant harm to the individual, and therefore, there should be guidelines for staff to follow. ▪ The PBSP for Individual #253 was revised on 6/18/13, approved by the Behavior Support Committee on 7/26/13, and implemented on 9/13/13. The primary changes were the addition of two replacement behaviors. These were designed to address other hypothesized functions of her problem behaviors. The delay in implementing this revised PBSP was concerning. A recommendation included in her July progress note stated: "Revised PBSP was approved and consent obtained; staff to be trained to competency on (individual) new PBSP." The	Noncompliance

#	Provision	Assessment of Status	Compliance
		August progress note included an identical recommendation. It is suggested that staff should have been trained immediately after the plan was approved and consent was obtained. The Facility remained out of compliance with this provision of the Settlement Agreement. When the team identifies necessary changes to programming and/or suggests revisions to the PBSP, these should occur as soon as possible.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The Facility process for review of a restraint required the Restraint Monitor to review the restraint checklist and document the review on the Face-to-Face form. The Behavior Health Specialist reviewed both forms in conjunction with completing the debriefing sheet. Within three business days of the restraint, the Unit Team was to review the restraint record, and the date of the review was to be noted on the Restraint Checklist. The Unit Team might not have the debriefing sheet at the time of their review, which could happen on the next day. The IMRT was to review the record within three business days, and the date was to be noted on the Restraint Checklist. The IDT was to review the restraint if it was one of more than three restraints in a rolling 30-day period or if it received a referral from the Unit Team or IMRT. In addition, the Restrictive Practices Committee reviewed individual restraints and monitored data for trends. This process was essentially the same as during the Monitoring Team's last review. One difference noted from the last visit was that the Restraint Reduction Committee was not attended by a majority of the members. While this did not prevent a review by the behavior specialists and others who did attend, the composition of the team should be reconsidered and policy adjusted, if the membership is expected to be different than currently specified in policy. A sample of documentation related to five incidents of crisis intervention restraint was reviewed, including Samples #C1.1, #C1.3, #C1.7, #C1.11, and #C1.15. The documents reviewed, included the Unit Team meeting minutes, the IMRT meeting minutes, the Restraint Reduction Committee minutes, any ISP addenda, and the debriefing form. This documentation showed that: ▪ a. In two (40%), the review by the Unit IDT occurred within three business days of the restraint episode and was documented by the signature on the Restraint Checklist. The cases where this did not occur were Sample #C.1.3, #C1.7, and #C1.15. In each of these cases the dates recorded indicated the Unit team did not review the case within three business days. ▪ b. In two (40%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented by signatures on the Restraint Checklist. The three that were not reviewed within three business days	Noncompliance

#	Provision	Assessment of Status	Compliance
		were Samples #C1.3, #C1.7, and #C1.15. ▪ c. In five (100%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. ▪ d. In none (0%), the review conducted by the Unit IDT and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. None of these five records contained minutes of Unit IDT or IMRT meetings that provided the information needed to establish the criteria listed. There were no records of discussions or decisions of any kind. While some boxes were checked to indicate the record had been presented to the teams, most comments were "missing data." ▪ e. In none (0%), referrals were made to the IDT. However, in four of the five, there were ISPAs that indicated the team had reviewed the use of restraint. It was not clear if the IMRT did not make referrals because they knew the IDTs were going to conduct reviews as a matter of practice. ▪ f. Since no referrals to IDTs were made, this metric was not applicable: "Of the ___ referred to the team, ____ appropriate changes were made to the individuals' ISPs and/or PBSPs." However, of the four reviewed by IDTs, changes were made in all four. Based on this review, the Facility remained out of compliance with this provision due to lack of documentation of review that should have been included in the minutes of the Unit IDT and IMRT meetings. Observation of a Unit IDT and an IMRT meeting during the onsite visit revealed discussion, problem solving amongst members and directions about follow-up activities. If this kind of discussion was the norm, it was difficult to understand why the minutes did not document those discussions and directions.	

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of the Following Documents**: o CCSSLC Self-Assessment, updated 3/14/14; o CCSSLC Action Plans, updated 2/13/14; o Presentation Book for Section D; o Abuse/Neglect/Exploitation (A/N/E) Investigations between 8/1/13 and 1/31/14, undated; o CCSSLC Abuse, Neglect, and Exploitation – Monthly Trending Report, from August 2013 through January 2014; o Investigations Conducted Solely by Facility between 8/1/13 and 1/31/14; o CCSSLC Unusual Incidents – Monthly Trending Report, from August 2014 through January 2014; o CCSSLC Combined Data Report, Representing Data for 12 months, date range from 2/1/13 through 1/31/14; o CCSSLC Staff Status Tracking – by Date, dated 8/1/13 to 1/31/14; o List of 12 individuals residing at CCSSLC who are currently on chronic caller list, dated 2/28/14; o Atlantic Unit Management Review Team Meeting Minutes for 4/2/14; o Centers for Medicare and Medicaid (CMS) Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) report of 3/7/14; o FY2014 Recommendations Tracking Log, October through February; o Executive Safety Committee minutes, dated 2/6/14; o **Sample #D.1**: included a sample of DFPS investigations of abuse, neglect, and/or exploitation, as well as the corresponding Facility investigation reports:

Sample #	Individual #	Date	Facility #	DFPS #	Type
D1.1	Individual #126	9/11/13	14-016	42864448	Verbal-unconfirmed
D1.2	Individual #7	9/15/13	14-024	42867813	Physical-unfounded
D1.3	Individual #312	9/23/13	14-034	42877138	Verbal-unconfirmed
D1.4	Individual #172	9/30/13	14-045	42884436	Sexual-unfounded
D1.5	Individual #191	10/8/13	14-052	42893435	Neglect-unconfirmed
D1.6	Individual	10/17/13	14-063	42903998	Neglect-

	#27				unconfirmed
D1.7	Individual #274	10/24/13	14-073	42912138	Neglect-confirmed
D1.8	Individual #174	11/7/13	14-085	42927972	Sexual-unconfirmed
D1.9	Individual #275	11/17/13	14-092	42937958	Neglect-unfounded
D1.10	Individual #191	11/20/13	14-099	42942166	Neglect-confirmed
D1.11	Individual #332	11/27/13	14-109	42949030	Physical-unconfirmed
D1.12	Individual #159	11/30/13	14-110	42950073	Physical-inconclusive
D1.13	Individual #182	12/6/13	14-120	42956824	Neglect-inconclusive
D1.14	Individual #218	12/12/13	14-130	42962644	Physical-unconfirmed
D1.15	Individual #348	12/27/13	14-139	42975438	Sexual-unconfirmed
D1.16	Individual #325	1/6/14	14-151	42983326	Physical-unconfirmed
D1.17	Individual #183	1/13/14	14-156	42990731	Neglect-Information and Referral
D1.18	Individual #35	1/22/14	14-161	43000926	Verbal-unconfirmed
D1.19	Individual #128	1/22/14	14-162	43001530	Neglect-confirmed
D1.20	Individual #72	1/30/14	14-168	43015033	Neglect-confirmed

- **Sample #D.2**: included a sample of five investigations selected from "Investigations Conducted Solely by Facility," from 8/1/13 to 2/28/14 (minus some data for August)

Sample #	Individual #	Date	Facility #	Type
D2.1	Individual #39	9/26/13	14-040	Unauthorized Departure (UD) off campus
D2.2	Individual #191	11/18/13	14-093	Suicide Credible
D2.3	Individual #298	12/6/13	14-118	UD off campus

D2.4	Individual #325	1/26/14	14-165	UD off campus
D2.5	Individual #253	1/10/14	Opened in error	Serious injury
D.2.6	Individual #268	2/19/14	14-180	UD off campus

- **Sample #D.3:** DFPS case #43074881, which occurred on 3/27/14;
- **Sample #D.4:** the sample Individual Support Plans (ISPs) was not drawn, since section D.2.e was not monitored for this review;
- **Sample #D.5:** a subsample of the investigations included in Samples #D.1 and #D.2. This included investigation reports in which programmatic recommendations were made and/or the IMRT made recommendations. Included in the sample were Samples #D.1.4, #D1.8, #D1.12, #D1.20, and #D1.19;
- **Sample #D.6:** no sample of Record Audits was drawn on this visit, since Incident Management Coordinator (IMC) indicated changes were being made to the process and record audits were not complete; and
- **Sample #D.7:** No action plans developed as a result of trend analysis were available for this section.

- **Interviews with**:
  - Mark Cazalas, Facility Director;
  - Brandon Riggins, Assistant Director of Programs;
  - Jon Breseman, Incident Management Coordinator
  - Carolyn Milton, Director of Behavioral Health Services,
  - Cynthia Velasquez, Director for Quality Assurance;
  - Beverly Okin-Larkin, System Analyst;
  - Kristina Sheets, Director of Residential Services;
  - John Henley, Unit Director for Atlantic;
  - John Cortez and Javier Luna, CCSSLC investigators;
  - Campus Administrators;
  - Program Compliance Monitors/QA Nurse;
  - Staff members from various residential locations; and
  - Individuals in various residential locations.
- **Observations of**:
  - QA/QI Council Meeting, on 4/3/14;
  - Atlantic Unit Team Meeting, on 4/2/14;
  - Incident Management Review Team meeting, on 4/2/14;
  - Residences: #515, #516, #522A, #522B, #522C, #522D, and the Infirmary #503; and
  - Vocational/day programs: #512, #513, and #523.

Facility Self-Assessment: The CCSSLC Self-Assessment indicated the Facility was in substantial compliance with 19 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team

found the Facility to be in compliance with 18 of the 22, the difference being Section D.3.i.

The Facility submitted a Self-Assessment for Section D, dated 3/14/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.

For Section D, in conducting its self-assessment:

- The Facility used monitoring/auditing tools. It was not clear whether the Facility used data drawn from State monitoring tool (no alternative tool was provided) in its self-assessment. The tool was not referenced in the self-assessment, there were no references to inter-rater reliability data, and the samples the IMC appeared to have drawn the samples, not the QA Department's data analyst.
  - The monitoring/audit tool that had been in use by the Facility consisted of a template entitled: "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section D – Protection from Harm – Abuse, Neglect and Incident Management."
  - The monitoring/audit tool included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tool was consistent with the provisions of the Settlement Agreement.
  - The monitoring tool included some adequate methodologies.
- The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size).
- It was not clear if there were guidelines to assure consistency in the evaluation of the samples.
- The Self-Assessment for Section D appeared to have been based on data, collected by the Incident Management Unit. It was not clear whether the IMC conducted the reviews himself or had other staff engaged in the reviews.
- Inter-rater agreement could not be established, because it was not clear who was rating the elements of the self-assessment.
- The Self-Assessment referenced some relevant data sources. For example, it used data from the Competency and Training Department database on A/N/E training and data produced from ongoing monitoring of 100% of ANE investigation reports and Unusual Incident Reports (UIRs) for timeliness of reports. The Facility did not present data on key indicators or outcome measures in its Self-Assessment. Such indicators were under development based on the State-provided guidelines.
- The Facility consistently presented some data in a meaningful/useful way. Specifically:
  - Many of the findings were presented as specific, measurable indicators. However, some indicators were missing. Just as one example, Section D.3.e included a number of requirements related to investigation reports. The Facility addressed three, but did not address recommendations for corrective action, which was an important element of D.3.e.
  - The Facility did not consistently measure the quality as well as presence of items.
  - The Facility did not distinguish data collected by the QA Department versus the program/discipline, if, in fact data from QA Department monitoring was used at all.
- The Facility did identify some of the areas in need of improvement. For example, Section D.4,

	which requires trend reporting, was identified as still in development. The Self-Assessment noted that the IMC had visited other Facilities to evaluate their systems for trend analysis and had put an action plan in place to address this provision. The action plan contained limited detail on the process to be followed other than to set out the timeline. However, on interview with the IMC and review of the most recent Combined Data Report, it was clear that considerable work had been done to develop a trend reporting system and to establish an Executive Safety Committee to monitor the trend data and to direct responses.
	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in substantial compliance with 18 out of 22 provisions of Section D, which was the same number of provisions that were in compliance during the last review. Progress was noted in a number of areas. Highlights of progress included: ▪ The Incident Management Coordinator's (IMC's) supervisory forms documented changes needed to complete reports and those changes were generally carried out. There was evidence that additional supervisory review of Unusual Incident Reports (UIRs) was ongoing, including marking up the preliminary UIR and returning it to investigators for corrections, as the report was moving toward its final version. ▪ The Review Authority Team (RAT) findings augmented the recommendations on each report, adding to or correcting the UIR. ▪ A tracking log for the recommendations that emerged from UIRs, Department of Family and Protective Services (DFPS) reports, and the Review Authority Team had been added to ensure timely submission of evidence that the recommendations had been implemented. ▪ An Executive Safety Committee had been established to analyze trended data and to make recommendations for program changes. Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included the need to: ▪ Establish the process for auditing injuries and include investigation of unusually large numbers of injuries or large numbers of peer-to-peer injuries, or patterns of injuries that are discovered either through the audit process or through the monthly reviews of trend data. ▪ Load the Quality Assurance (QA) monitoring data into the system so that it can be compared with the IMC unit data to establish a healthy check on performance and reference that data in the Facility Self-Assessment. ▪ Review the recommendations from investigations involving unauthorized departures and ensure those recommendations fully address the issues identified and are fully implemented. In addition, for the protection and improvement of the lives of all individuals who live at the Facility, as appropriate, recommendations should address systemic issues that have the potential to impact others, and should not be viewed as isolated to the specific individual or circumstance. For example, issues related to teams' assignment of levels of supervision should be addressed across campus, and not just for individuals for whom higher levels of supervision were assigned due to histories of unauthorized departures. ▪ Improve the timeliness of UIRs, both those that follow DFPS investigations and those that are

	Facility-only investigations. DFPS report #43074881, which investigated an incident that occurred on 3/27/14, was reviewed because it involved a comminuted hip fracture (one in which the bone is broken in multiple places) of unknown origin. The DFPS report confirmed that there was a failure by an unknown person to recognize or react to trauma or that staff used improper transfer methods that resulted in the fracture. However, no alleged perpetrator could be identified. The report recommended that staff provide closer supervision and be alert to anything that might cause trauma and that the vehicle drivers maintain logs on the vehicles so that it would be possible to identify who was driving when individuals were transported. It was difficult to understand why the staff involved with this individual during the hours preceding discovery of the injury could not all be identified. Even if the specific perpetrator could not be identified, it would have been important for the staff responsible for the care of the individual to be identified and retrained to competency on signs and symptoms of illness, as well as proper transfer methods.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that	Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.

According to data the Facility provided in a document entitled Data Charts – Incidents, the numbers of abuse/neglect/exploitation allegations for the past two six-month periods were:

<table>
<tr><th></th><th>3/1/13 to 8/31/13</th><th>9/1/13 to 2/28/14</th></tr>
<tr><td>Total abuse allegations</td><td>336</td><td>199</td></tr>
<tr><td>Physical</td><td>196</td><td>105</td></tr>
<tr><td>Verbal/Emotional</td><td>20</td><td>65</td></tr>
<tr><td>Sexual</td><td>120</td><td>29</td></tr>
<tr><td>Abuse substantiated</td><td>16</td><td>7</td></tr>
<tr><td>Physical</td><td>14</td><td>5</td></tr>
<tr><td>Verbal/Emotional</td><td>0</td><td>2</td></tr>
<tr><td>Sexual</td><td>2</td><td>0</td></tr>
<tr><td>Total neglect allegations</td><td>146</td><td>103</td></tr>
<tr><td>Neglect substantiated</td><td>20</td><td>16</td></tr>
<tr><td>Total exploitation allegations</td><td>0</td><td>0</td></tr>
<tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr>
</table>

According to data provided in a document the Facility provided in response to an onsite request, the numbers of Unusual Incidents investigated over the past two six-month periods included:

<table>
<tr><th></th><th>3/1/13 to 8/31/13</th><th>9/1/13 to 2/28/14</th></tr>
<tr><td>Deaths</td><td>2</td><td>3</td></tr>
<tr><td>Serious Injuries</td><td>14</td><td>4</td></tr>
<tr><td>Sexual Incidents</td><td>1</td><td>3</td></tr>
<tr><td>Suicide Threat (credible)</td><td>1</td><td>1</td></tr>
<tr><td>Unauthorized Departure</td><td>3</td><td>14</td></tr>
<tr><td>Choking</td><td>0</td><td>0</td></tr>
<tr><td>Other</td><td>7</td><td>5</td></tr>
<tr><td>Total</td><td>28</td><td>30</td></tr>
</table>

Metric 2.a.1: Based on the Monitoring Teams' review of DADS' revised policies, including</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements. Metric 2.a.2: According to CCSSLC Policy D: Protection from Harm – ANE Policy, and D.2 Reporting Abuse, Neglect, Exploitation, staff were required to report abuse, neglect, and exploitation immediately or at least within one hour by phone to the Director and to the DFPS number. This was consistent with the Settlement Agreement requirements. Metric 2.a.3: With regard to unusual/serious incidents, the Facility policy entitled CCSSLC Policy D – Serious Event Notification required staff to report unusual/serious incidents within one hour from the time of discovery. The process for staff to report such incidents required staff to call the Director or designee. This policy was consistent with the Settlement Agreement requirements. Metric 2.a.4: Although not used to assess compliance, based on responses to questions about reporting, 10 of 10 (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Metric 2.a.5: Although not used to assess compliance, based on responses to questions about reporting, 10 of 10 (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents. Based on a review of the 20 investigation reports included in Sample #D.1: ▪ Metric 2.a.6: 19 (95%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy or the time of the event was unknown, there was not reasonable cause to believe an allegation had occurred, or the allegation was not confirmed. In the one that did not: o Sample #D1.20 involved an unauthorized departure, and ultimately the individual was not located and was eventually found deceased. The unauthorized departure was reported within an hour of discovery and the investigation began as a Facility investigation. The UD was reported as an allegation of neglect on 2/3/14 to DFPS and DFPS proceeded with the investigation. The search for the individual was ongoing and it might not have been immediately apparent that the event was more than a UD. DFPS did confirm system neglect. ▪ Metric 2.a.7: Twenty (100%) included evidence that allegations of abuse,	

#	Provision	Assessment of Status	Compliance
		neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. ▪ Metric 2.a.8: For the one allegation for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, Sample #D1.20, the UIR/investigation folder did not include recommendations for corrective actions. However, given the complexity of the events surrounding the individual's unauthorized departure, it might have taken some time to understand that the departure was the result of program changes related to levels of supervision. However, this deviation should have been explained in the report. Based on a review of five investigation reports included in Sample #D.2: ▪ Metric 2.a.9: Five (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by Facility policy or the individual was self-reporting ingestion of a foreign object or the time of the incident was unknown. ▪ Metric 2.a.10: Five (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. ▪ Metric 2.a.11: There were no incidents in this sample where the staff did not follow policy. Had there been, the following metric would have been assessed: "For the __ unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, ___ UIRs/investigation folders (__%) included recommendations for corrective actions." Metric 2.a.12: The Facility had a standardized reporting format. Metric 2.a.13: Based on a review of 26 investigation reports included in Samples #D.1 and #D.2, 25 (100%) contained a copy of the report using the required standardized format and were completed fully. Based on this review, the Facility remained in substantial compliance with this provision. However, the Facility should assure that any deviation from the timeframes for reporting is fully explained in the reports.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.		
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for at least three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.		
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	A copy of the "State Supported Living Procedure: Injury Audits," dated March 2013, and the associated record review form were provided. On interview, it was learned that the process described in these documents had been tried on a small scale, and the process was judged to be unworkable for campus-wide application. As a result, the Action Plan for this section included steps to revise the procedure, to train Campus Administrators in the procedure, and to apply the procedure to a test sample. The end date for the Action	Noncompliance

#	Provision	Assessment of Status	Compliance
		Plan was 3/31/14. Metric 2.i.1: The Facility policy and/or procedures did not define sufficient procedures to audit whether significant injuries are reported for investigation, such as who would conduct the reviews and what reports would be done, based on the data. Metric 2.i.2: The Facility had not conducted audits at least semi-annually, during the preceding 13 months. The following metrics were not reviewed since audit samples were not available, but will be reviewed during the next monitoring visit: ▪ Metric 2.i.3: The audits conducted were/were not sufficient to determine whether significant resident injuries had been reported for investigation. ▪ Metric 2.i.4: ____ of ____ (%) significant injuries identified by the audit that had not previously been investigated were reported to the Facility Director, and/or DFPS, as appropriate. The Monitoring Team found some issues with injury data during this visit. Specifically, when comparing the list of fractures provided to the physician on the Monitoring Team (IX.24B) with the list provided for Section D of serious injuries that were investigated, it appeared that several fractures to fingers or toes were not reported for investigation. These included injuries to Individual #58 on 8/3/13, Individual #304 on 8/28/13, Individual #161 on 9/5/13, and Individual #186 on 1/16/14. According to the Incident Management Policy, a serious injury is any injury requiring medical intervention by a physician, physician's assistant, or advanced practice nurse, and requires reporting for investigation. It was not clear why these injuries were not reported. In addition, Individual #356 who had sustained a non-displaced fracture to the distal right fibula on 9/11/13 did not appear on the list of investigations. This suggested that serious injuries might not have been reported for investigation or might not have been recorded in the data system. If true, this would mean the reports generated through the data system were unreliable. Another issue involved the presence of at least four hip fractures noted by the Monitoring Team's physician in the last six months. Three had been investigated and a fourth had not. All four of the fractures should be reviewed for any commonalities of practice that might have contributed to the injuries and if there were any, action should be taken to address the underlying causes. The purpose of this provision of the Settlement Agreement is to assure that injuries are properly reported, entered into the data system, and investigated. As these issues illustrate, it will be critical to sustain a quality incident management system, and that the	

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		data is accurate and reviewed regularly for patterns that could benefit from investigations. The Facility was not in compliance with this provision, because the procedures were incomplete and audits were not available for review. The Facility found the same in the Facility Self-Assessment. An Action Plan was provided that indicated revisions were in process, including when procedures would be updated and in place and specifying the staff that would conduct the audits. The Action Plan needed to include modifications to the electronic data system to allow access to staff responsible for the audits. It is important that this process get underway as soon as possible.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(c) Ensure that investigations are	The parties agreed the Monitoring Team would not monitor this provision, because the	Substantial

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	coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	Based on Section DD.10 and DD.11 of the CCSSLC Policy and Procedure Manual, investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations. ▪ 20 out of 20 (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. ▪ 19 out of 20 (95%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. The one that was not was Sample #D1.20. ▪ For one that was not completed within 10 days, one (100%) had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. ▪ 20 (100%) resulted in a written report that included a summary of the investigation findings. ▪ In four of the investigations reviewed, recommendations for corrective action	Noncompliance

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		were included. In four of the investigations (100%), the recommendations were adequate to address the findings of the investigation. <u>Facility-Only Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Five out of five (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. ▪ One out of five (20%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. The one was Sample #D2.1. ▪ For the four that were not completed within 10 days, none (0%) had documentation of a written extension request that had been approved by the Facility Director, including documentation of the extraordinary circumstances that necessitated the extension. ▪ Five (100%) resulted in a written report that included a summary of the investigation findings. ▪ None of the five investigations reviewed included recommendations for corrective action and in four (80%) none were needed. For one investigation (#D2.4), the reason for the individual's unauthorized departure from campus might have been related to concerns over his potential community transition. The investigator should have recommended the IDT review his transition plans. Based on the untimely completion of Facility investigations and the need to consider stronger recommendations regarding unauthorized departures and related findings in investigations, the Facility was not in substantial compliance with this provision. The Facility's finding in its Self-Assessment was the same.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.		
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Metric 3.g.1: The Facility policy and procedures did require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation was complete; and 2) the report was accurate, complete, and coherent. Metric 3.g.2: The Facility policy did require that any further inquiries or deficiencies be addressed promptly. <u>DFPS Investigations</u> The parties have agreed that due to concerns related to the confidentiality of the DFPS supervisory process, the Monitoring Teams will not review it. As a result, the Monitoring Teams make no judgment regarding the adequacy of the DFPS supervisory process, and it has not been taken into consideration in assessing compliance for this subsection. <u>UIRs related to DFPS Investigations</u> It was noted in discussions with the IMC that corrections to UIRs that accompanied DFPS investigations were sometimes made before finalization of the UIR as mark-ups to preliminary versions of the UIR and before the Supervisory review. Such interim reviews and mark-ups helped to assure that the final UIR would be in good order before the final review by the IMC.	Substantial Compliance

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		Facility-Only Investigations The supervisor reviewed Facility investigations at the time the reports were completed by the investigator and signed by the Director. The following summarizes the results of the review of Facility investigations: ▪ Metric 3.g.8: Five of five (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. ▪ Metric 3.g.9: In five out of five investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ▪ Metric 3.g.10: For one (i.e., Sample #D2.6), the supervisor had identified concerns. For this one investigation (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. ▪ Metric 3.g.11: For the one investigations noted above for which the Monitoring Team identified deficiencies (#D2.4 in Section D.3.e), the supervisory review did not appear to address these deficiencies. This provision remained in substantial compliance, since the supervisor was reviewing the Facility-Only UIRs within five days of the investigator completing the reports. In the one instance in which the Monitoring Team identified a deficiency, the supervisory review had not recommended review of the individual's transition plans. Although, the Immediate Corrective Actions Taken section of the UIR noted that the IDT would be meeting to review the increase in Level of Supervision to one-to-one, it was not clear that the recommendation included review of the individual's transition plan. This appeared to be an isolated incident in a system that otherwise appeared to be identifying problems and correcting them and the Facility remained in substantial compliance.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and	Metric D.3.i.1: The Facility policy and procedures did require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. Metric D.3.i.2: In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes. Specifically, Facility Policy D.14, entitled Participating In and Completing Review Authority Team,	Noncompliance

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	track and document such actions and the corresponding outcomes.	revised on 5/22/11, designated the Review Authority Team to review all final DFPS reports and make recommendations to the Director for approval. The responsibilities of the Team also included follow-up tracking of all recommendations made by the Team. The policy provided a format for making recommendations, and prescribed a method for tracking the recommendations in the Incident Management Review Team minutes, and recording them in the investigative report. The Facility had added a Recommendations Tracking Log to monitor the progress and completion of recommendations that passed through the IMRT. While the log appeared to be useful as an overview, it did not reference all of the recommendations found in the UIRs. Metric D.3.i.3: For three out of three of the investigations reviewed in which disciplinary action was warranted (100%), prompt and adequate disciplinary action had been taken and documented. These were samples #D1.7, #D1.10 and #D1.12. Based on a review of a subsample of five investigations for which recommendations for programmatic action were made (Sample #D5 in the documents reviewed list), the following was found: ▪ Metric D.3.i.4: For three out of five of the investigations reviewed (60%), prompt and thorough programmatic action had been taken and documented. I o In one, Sample #D1.19, where an individual choked on a dessert of apple pieces that were not served in the proper texture and where the diet card was not clear about the texture of the apples, the recommendation to clarify the diet card was done immediately and noted in the DFPS report. A second recommendation to review and retrain staff on dining procedures did not appear to have been addressed and was not being tracked on the UIR. o In Sample #D1.20, an individual left the campus without authorization which led to his death. DFPS found systemic neglect by the Facility for reducing the individual's level of supervision from one-to-one to routine without considering an interim step. Recommendations from DFPS included reconsideration of the Facility practice of restricting the use of enhanced supervision (an intermediate step) and careful consideration of the history of the individual's known behaviors when deciding on a reduction in level of support. While it was clear that the Facility was engaging in a review of their LOS practices, it was not complete and given the potential implications, it should have been completed with much more of a sense of urgency. The UIR contained additional recommendations including retraining staff campus-wide on any revised LOS process, but that could not be completed until revisions to	

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		the policy were made. However, it was evident in the town meeting held at the Facility, that the Facility Director was taking steps to erase any misunderstandings about the use of one-to-one supports prior to the issuance of formal directions. It was not clear that instructions had been given to staff about how to consider the prior history of behaviors for individuals before reducing levels of support. ▪ Metric D.3.i.5: For two out of five investigations (40%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic action, or when the outcome was not achieved, the plan was modified. The three that did not were: o Sample #D1.12: One recommendation was to retrain staff on the use of electronic devices such as cell phones, since it had been noted that staff were using such devices while assigned to a one-to-one level of support and had not been attentive to their assigned individuals. Evidence was produced that showed staff in the residence had been trained on the policy in October 2013. However, since the staff were continuing to misuse cell phones in November 2013, clearly additional training and some monitoring were needed to assure the desired outcome was achieved. o Sample #D1.19: This investigation involved an individual who choked on her dessert of apple pieces. One recommendation was to review the staff responsibilities in the dining room with regard to checking the texture of the meal against the card and provide training to staff. There was no evidence that such a review had been done, that staff had been retrained, or that checking was being done and documented to assure that whatever training was provided had the desired outcome. o Sample #D1.20 involved an individual who left the Facility without authorization after his team substantially reduced his level of supervision from one-to-one to routine. One recommendation was for the Facility to review its use of enhanced staffing in order to provide an intermediate alternative between routine level of support and one-to-one supervision. Although the Facility was in the process of finalizing a new policy related to levels of supervision, there was no plan to describe how the outcome of such changes would be monitored, or how the Facility would determine if proper levels of supervision were in place for other individuals for whom teams might have reduced supervision levels. These were essential follow-up activities to ensure that individuals were protected from harm. The Facility had created a chart to track recommendations and outcomes from incident investigations, separate from the IMRT minutes, but it was updated at meetings. The	

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		chart did track incidents that went through the IMRT, but it was difficult to match the information on the chart with the incidents in the samples. The chart included information about the incident, the person assigned to take the specified action, a due date for completion, a column for email follow-up, and a column to record the completion date. The process was implemented on 10/11/13, and there were charts for each month since then. The one thing missing appeared to be a column to record the actions taken to check on the success of the recommendation's implementation in meeting the desired outcome. For example, if staff were to be retrained in a meal support program, how would the Facility decide if the training had had the desired effect. The Facility was not in substantial compliance with this provision. It will be important for the Facility to follow its policy for addressing recommendations and provide the documentation that each step is accomplished. The Facility Self-Assessment found this provision to be in substantial compliance based on checking a sample of investigations for conclusions, but not for whether the outcomes had been achieved.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	To conduct this review, the trend reports for A/N/E, Unusual Incidents, and Injuries for the months of August 2013 through January 2014 were examined. The Facility made a major change in how data was displayed, adopting a "Combined Data Report." This report was done for the first time for the period of 2/1/13 through 1/31/14. The report displayed data by month across six categories and across two fiscal years plus the first five months of FY2014. This allowed data on abuse/neglect, injury, peer-to-peer injury, slip-trip-fall injury, restraint and unusual incidents to be displayed together. As a result, it was possible to determine which individuals were experiencing the most difficulties as described by the data, or which homes had the most difficulties. This kind of analysis, when combined with narrative analysis, had the potential to focus individual and systemic action toward some of the more intractable problems. The Facility also had instituted an Executive Safety Committee whose job will be to examine this data and recommend corrective action to address identified issues. This was a major step forward toward making use of the data that is being collected in so many facets of life at CCSSLC. The results of these changes will not be apparent in the following metrics,	Noncompliance

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		since they had not been in place long enough. However, the changes showed great promise. Metric D.4.1: For all unusual incident categories and investigations, the Facility did have a complete system that allowed tracking and trending by: ▪ Type of incident; ▪ Staff alleged to have caused the incident; ▪ Individuals directly involved; ▪ Location of incident; ▪ Date and time of incident; ▪ Cause(s) of incident; and ▪ Outcome of investigation. Over the past two quarters, the Facility's trend analyses: ▪ Metric D.4.2: Were conducted at least quarterly; ▪ Metric D.4.3: Did address the minimum data elements; ▪ Metric D.4.4: Did use appropriate trend analysis procedures including graphing data over a rolling 12-month period and using graphics to display data; ▪ Metric D.4.5**:** Did not provide a narrative description/explanation of the results and conclusions; and ▪ Metric D.4.6: Did not**,** as appropriate, contain recommendations for corrective actions. For example, while there were large numbers of injuries or peer-to-peer incidents for a number of people, there were no recommendations for corrective action. Likewise, certain homes had large numbers of incidents, allegations and injuries, but there were no recommendations for corrective action. Metric D.4.7: Based on a review of trend reports, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified, corrective action plans were not developed. Metric D.4.8: As appropriate, corrective action plans were not developed both for specific individuals and at a systemic level. For example: ▪ The Combined Data Report for January 2014 showed one individual (i.e., Individual #348), who had been identified as involved at a high level in seven of eight major data collection categories, such as abuse/neglect, injury, peer-to-peer injuries, and crisis intervention restraint. However, no plan of correction was in place. Such a finding should have triggered further investigation and an outside look beyond referral back to the IDT. Metric D.4.9: The trend reports and/or minutes did not show that corrective action plans were implemented and tracked to completion.	

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		Metric D.4.10: The report/minutes did not review, as appropriate, the effectiveness of previous corrective action plans, since no corrective action plans appeared on the CAPs tracking sheet. The following action plans were not rated since no action plans/corrective action plans based on trend tracking and analysis were found. However, these metrics will be reviewed at the next monitoring. Based on a review of resulting action plans and documentation related to implementation: ▪ Metric D.4.11: ___ out of ___ action plans (__%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. ▪ Metric D.4.12: For ___ out of ___ of the action plans reviewed (___%), the plan had been timely and thoroughly implemented. ▪ Metric D.4.13: For ___ out of ___ action plans (___%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. The Monitoring Team found the Facility was not in substantial compliance with the requirements of this provision, as did the Facility in its Self-Assessment. While the system for tracking and trending data over time was in place, a promising combined data report had been in use for a month and the Executive Safety Committee was in place and had held one meeting. However, the results from these changes were not yet apparent.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.		

<table>
<tr><th>SECTION E: Quality Assurance</th><th></th></tr>
<tr><td>Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

Review of Following Documents:

DADS Policy #003.1: Quality Assurance (QA), dated 1/26/12;
CCSSLC Policy #003.2, dated 5/22/13;
Quality Assurance E.10: Developing, Implementing and Tracking Corrective Action Plans, dated 5/24/12 (presented as having been approved by QA/QI Council on 12/5/13 for implementation on 12/23/13);
Presentation Book for Section E;
CCSSLC Administrative Outcome Measures, undated;
CCSSLC Corrective Action Plan (CAP) Template, revised 4/18/13;
CCSSLC CAP Tracking, undated (TX-CC-1403-IV.10);
CCSSLC Quality Assurance Plan, revised 1/17/14;
CCSSLC Self-Assessment, dated 3/14/14;
CCSSLC Action Plan for Section E, dated 2/3/14;
CCSSLC Trend Analysis Report: Allegations of Abuse/Neglect/Exploitation, August 2013 – January 2014;
CCSSLC Trend Analysis Report: Injuries, August 2013 to January 2014;
CCSSLC Unusual Incidents Trending Reports, August 2013 to January 2014;
CCSSLC Restraints Trend Analysis Reports, August 2013 to January 2014;
CCSSLC Combined Data Report, Representing Data for 12 months, date range from 2/1/13 through 1/31/14;
CCSSLC Quality Assurance/Quality Improvement Council meeting notes, dated 8/15/13 to 3/20/14;
CCSSLC Quality Assurance/Quality Improvement Council meeting agenda and handouts, for meeting on 4/3/14;
Monthly Program Compliance Monitor Data and Summary reports for:
<table>
<tr><td>C: None</td><td>M: None</td></tr>
<tr><td>D: February 2014</td><td>N: None</td></tr>
<tr><td>E: February 2014</td><td>O: January 2014</td></tr>
<tr><td>F: August to October 2013</td><td>P: January 2014</td></tr>
<tr><td>F and S: February to April 2014</td><td>Q: None</td></tr>
<tr><td>G: None</td><td>R: January 2014</td></tr>
<tr><td>H: None</td><td>S: August – October 2013</td></tr>
<tr><td>I: February 2014</td><td>T: October 2013</td></tr>
<tr><td>J: August – October 2013, November 2013 - January 2014, and February 2014</td><td>U: August 2013</td></tr>
<tr><td>K: None</td><td>V: January 2014</td></tr>
<tr><td>L: None</td><td></td></tr>
</table>

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</table>

	Note: Quality Assurance for medically related sections was being done in the Medical Services Department. However, any quality assurance reports generated in Medical Services were not presented as reports submitted to and reviewed by the QA Department. ▪ **Interviews with**: o Mark Cazalas, Facility Director; o Brandon Riggins, Assistant Director of Programs; o Jon Breseman, Incident Management Coordinator; o Cynthia Velasquez, Director for Quality Assurance; o Beverly Okin-Larkin, System Analyst; o John Henley, Unit Director for Atlantic; o Program Compliance Monitors; o Staff members from various residential locations; and o Individuals in various residential locations. ▪ **Observations of**: o QA/QI Council Meeting, on 4/3/14; o Atlantic Unit Team Meeting, on 4/2/14; o Incident Management Review Team meeting, on 4/2/14; o Residences: #515, #516, #522A, #522B, #522C, #522D, and the Infirmary #503; and o Vocational/day programs: #512, #513, and #523
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 3/14/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section E, in conducting its self-assessment: ▪ The Facility did not use the Section E monitoring/auditing tool in its analysis; ▪ The Facility did use other relevant data sources, such as data from CAP tracking sheets, QA activities, PCM activities, and reports and QA/QI Council meeting minutes. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did not present findings consistently based on specific, measurable indicators. For example, for Section E.2, the Self-Assessment indicated that the Facility reviewed "collaborative efforts with other departments…" without specifying where such efforts were documented. o Did not consistently measure the quality as well as presence of items. For example, for Section E.2, one activity engaged in to review the section was listed as: "Reviewed CAPs to determine if they contain measurable outcomes to assess effectiveness." However, the results indicated only that CAPs were implemented and completed as necessary with no comment on whether outcomes were measurable. ▪ The Facility rated itself as being in compliance with one of the subsections of Section E (i.e., Section E.3). This was not consistent with the Monitoring Team's findings. While the Facility presented four CAPs, listed dates of dissemination and presented emails to confirm dissemination, the CAP tracking

	sheet indicated that one of those CAPs had to be extended due to "failure of the dissemination process to reach all involved." ▪ The Facility data did identify some areas in need of improvement. For example, for Section E.2, the Facility found that the QA/QI Council was not regularly reviewing data and analyses, such as the trend reports for restraints and Unusual Incidents. ▪ The Facility did include Action Steps for Section E.
	Summary of Monitor's Assessment: The Facility was in substantial compliance with none of the subsections of Section E. Since the Monitoring Team's last monitoring visit, the Facility had made some progress with regard to Section E, including: ▪ The Data Inventory had been refined and updated, providing an excellent overview of the data available at the Facility and the reports that were generated from the data. ▪ The Quality Assurance (QA) Plan had been reviewed and revised to include descriptions of QA personnel. ▪ A preliminary listing of key indicators was available. Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included: ▪ While the QA plan had been improved to include reference to the data inventory and specific descriptions of the responsibilities of QA staff, there were a number of adjustments needed, such as adding a section on Key Indicators under the data collection/analysis and a section describing the responsibilities of other departments. This should include a description of the role of the Facility Director in relation to quality assurance efforts. ▪ A list of key indicators was under development, but it was not clear that the list was finalized, what data was being collected, or how the data for the key indicators would be managed, reported, or addressed. The list presented was extensive and in need of review by Section Leads with some editing to reflect the priorities of the Facility. Whatever indicators are finally adopted, data sources will need to be identified for each indicator. A lot more work needs to be done to design methodologies for the collection of accurate data for indicators, as well as to set benchmarks or target goals. ▪ The monitoring tool for Section E needed revision to provide a valid assessment of progress toward substantial compliance. ▪ The Corrective Action Plans (CAPs) tracking needed to include the method and dates of dissemination, and name of the person responsible for assuring the dissemination is completed. ▪ A system was needed to measure whether or not CAPs were achieving the desired outcomes, and, if not making revisions to the plans. ▪ CAPs needed to address issues, identified through data collection and analysis. The Facility should consider having the Program Compliance Monitors (PCMs) take a more active role in assisting Section Leads to analyze data and select potential CAPs.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	<u>State QA policy</u> There was a State Office policy that adequately addressed all five of the provision items in Section E of the Settlement Agreement. There were no changes to the DADS policy, entitled #003.1: Quality Assurance, dated 1/26/12. The Monitoring Teams' comments on the State Office policy are in the previous monitoring report and are not repeated here. Also, given that the statewide policy was disseminated almost two years ago, edits may be needed. State Office should consider this. <u>Facility QA policies</u> The Facility had added Facility Policy #003.2, dated 5/22/13, to operationalize the State Office policy. It appeared to be consistent with the DADS policy. According to the QA/QI minutes of 12/5/13, revisions were made to Facility policy E-10 for implementation on 12/23/13. It appeared to be consistent with the State Office policy. <u>QA Data Inventory</u> The Facility maintained a data inventory that identified data for all sections of the Settlement Agreement that could be used to identify trends related to the requirements of those provisions. The list included the data collected, the collection frequency, data/report availability, collection method, responsible staff, reports yielded, and location for Facility usage. Those sections for which data was not identified included: ▪ Section F: The list did not identify data related to the specific activities of the IDTs, including, but not limited to dates of and reasons for amendments to ISPs, or progress on skill acquisition programs (SAPs), which would be needed to track compliance with the Settlement Agreement. ▪ The data inventory did not include data on key indicators (outcome and process) of performance, selected by the QA/QI Council to track priorities, because that list was still under development. The data inventory included data from: disciplines/departments, areas of care, protections and supports. The Data Analyst, in interview, indicated that all data in AVATAR could be sorted according to program areas, living units, work shifts, and individuals. There did not appear to be any Facility policy or procedure specifying the creation and maintenance of a data inventory, although the Quality Assurance Plan did mention a data list. The data inventory had been updated on 2/9/14 and was updated as new data was identified for collection or additional reports were required. However, to ensure that the process will endure, there should be a section of the QA Plan/Policy that describes the data inventory, how it will be maintained, and how often it will be updated.	Noncompliance

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		The data inventory had been arranged by Section of the Settlement Agreement, making it easy to determine where data related to sections were located. <u>QA Plan Narrative</u> The QA plan narrative at the Facility was current. The date on the most recent copy of the Quality Assurance Plan was 1/17/14, indicating that it had been reviewed and revised within the last 12 months. The Plan included improvements over the previous plan, but needed some additional work to be complete. The QA Plan described the QA program, including: ▪ A description of the purpose of the QA program was included. ▪ The organizational structure of the QA process, including an organizational chart for the QA Department was included. ▪ The data list/inventory was available. ▪ The QA matrix was included. ▪ Key indicators of performance were included with the plan. However, the list was extensive, and there was no indication that Section Leads had reviewed it in an effort to edit it to include the indicators of primary importance to the Facility. The QA Plan narrative needed to include a description of key indicators and their relationship to the plan. ▪ A description of how data were summarized was included, but did not provide information on how the data collected would be analyzed or who would do it. For example, the plan indicated data on abuse/neglect/exploitation would be analyzed and trended, but it was not clear that the analysis would result in explanations of the data trends and include recommendations. The work of the Executive Safety Committee, described in Section D of this report, might fill this role. If so, that needs to be stated in the QA Plan. ▪ The role of other departments in QA was not clearly described. There was no detail about what was expected of Section Leads. For example, roles would likely be to collect data using the monitoring tools, to meet regularly with assigned PCMs to review and analyze the data, and to prepare CAPs when needed. ▪ The QA Council description included a list of quality assurance related committees and the expectations that they report regularly to the Council. ▪ The QA Plan did not describe what reports the QA Director would issue. On interview, it appeared that the QA Director provided information based on the monitoring of sections of the Settlement Agreement to the Section Lead in conjunction with the Lead's quarterly report to the QA/QI Council. This needed	

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		to be described in the QA Plan. ▪ QA/QI Council and its role in reviewing data and guiding the entire QA process were included. ▪ A revised description of Corrective Action Plans and how they are developed was included. However, the direct connection between data collection, analysis, and corrective action plans was not explained, so that it was clear that corrective action plans would be data based. <u>QA Plan Matrix</u>: The QA Plan Matrix listed the data to be submitted to the QA Department. These data were then included in the QA report sections of quarterly section updates to the QA/QI Council. 1. <u>Key Indicators</u>: ▪ For the 20 sections of the Settlement Agreement, a set of key indicators was included for 20 of the 20 sections (100%). While a list of key indicators was provided for all sections, it was not clear that Section Leads had reviewed and edited it to assure that the list would meet the needs of the Facility, or that the data to address the indicators had been identified. The indicators were specific, but it was not clear if the indicators represented important priorities for the Facility. As a result, it could not be determined if the Facility had developed an adequate set of quality indicators. Since it was not clear that the provided list of key indicators was the final list, the following were not rated: ▪ Of these ___, both process and outcome indicators were identified for ___% of the sections. ▪ Of these____, in ___% the indicators provided data that could be used to identify the information specified in E.1: trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports. 2. <u>Self-monitoring tools for all Settlement Agreement provisions</u>: The QA plan matrix included self-monitoring tools or self-monitoring procedures for the 20 sections of the Settlement Agreement. According to the information provided in response to the document request, the State Office monitoring tools were being used for all sections except: F, G, J, K, N, S, and T. The matrix identified the frequency of monitoring and the person responsible for monitoring.	

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		3. <u>All Data Collected by QA Department:</u> All data that QA staff members collected were not listed on the matrix. For example, Section M had multiple tools, but this was not clear on the matrix. There was no reference to data collected for trend analyses reports or for key indicators (except for Section Q), although this would have been premature, since the list of key indicators had not been finalized. 4. <u>All Items in QA Plan Matrix Also Appear in the QA Data Inventory</u>: All items in the QA Plan Matrix also appeared in the QA Data Inventory except that only one of the four Section T forms was listed. 5. <u>All data in QA plan matrix are submitted and received:</u> The most recent QA data summaries were requested for all sections. Based on those summaries: Of the 20 sections in the QA plan matrix, nine (45%) were submitted to/collected by/received by the QA Department for at least one reporting period. The sections that were submitted included Sections: E, F, J, O, P, R, T, U, and V. The PCM, but not the Section Lead collected data for Sections D, I, and S (prior to consolidation with F.) Most of the medical/dental/nursing data was not evident in the supplied summaries, although they might have been done. There should be evidence in the QA Department that all data listed in the matrix has been submitted to and received by the QA Department. 6. <u>Data in the QA Plan were Reviewed and Analyzed</u>: Of the 20 sections in the QA matrix, 11 were documented to show review or analysis by the QA department and/or the department Section Leads for the last reporting period. This included Sections D and I, for which only the PCM had provided data. The quality of these reviews is discussed with regard to Section E.2. While many of the reviews summarized monitoring data, none of the reviews appeared to include a comprehensive analysis of that data, including how the data was trending (changing over time), such that it could provide guidance in determining what corrective action plans might be needed. <u>Implement the QA Plan as Written</u> The Monitoring Team did not attempt to quantify the following metric for this report: Of the ___components of the QA plan narrative and QA plan matrix, the Facility implemented ___%. <u>QA Staff Assist Disciplines/Departments in Analysis of Data</u> Documentation and observation did not indicate that QA staff assisted each discipline in	

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		analysis of data, or if there was no assistance provided, that there was documentation that it was not needed. For the 19 sections of the Settlement Agreement (Section E excluded), data summaries prepared by the PCMs indicated that the PCMs provided at least some assistance to ten (D, F, I, J, O, P, R, T, U, and V) Section Leads with analysis. For those sections without documentation of assistance, there was no documentation of the reasons that assistance was not needed. The reviews summarized monitoring data, displayed some data in graphs, and commented on areas where action might be needed. However, few of the reviews appeared to include a comprehensive analysis of that data (for example showing how the data had/had not changed over time), such that it could provide guidance in determining what corrective action plans might be needed. <u>Self-monitoring Tools/Activities for all Sections of the Settlement Agreement</u> As the QA Director and the Department Section Leads work towards improving the self-monitoring tools, the Facility should be prepared to present to the Monitoring Team the following information on aspects of the self-monitoring tools: 1. <u>Content/validity</u>: A description of how the content of the tools were determined to be valid (i.e., measuring what was important) and evidence that each tool received a review by QA/QI Council at least twice within the past six months. Metric to be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, (a) the content of ___ (%) appeared to be appropriate and (b) __ (%) were reviewed within the past six months, and revised as appropriate. While this area was not evaluated, one example of monitoring tool validity was evident and illustrates the importance of tool validity. The Facility's results for the February 2014 monitoring of Section E indicated 100% compliance with all five provisions of the Settlement Agreement's Section E. Yet, in its Self-Assessment, the Facility found noncompliance in four of the five provisions. Clearly, the Section E tool was not a valid measure of compliance and needs to be revised. 2. <u>Adequate instructions</u>: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. Metric to be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, ___ (%) had adequate instructions for the user. 3. <u>Implementation</u>: A report or summary showing whether the tools were implemented as per the QA matrix. Metric to be measured: Since the last onsite review, of the self-monitoring tools for the 20	

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		sections of the Settlement Agreement, ___ (%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-observer agreement). 4. <u>QA review</u>: A report or summary showing that there was documentation of QA Department review of the results of the monitoring, at least once each quarter, for each of the 20 sections of the Settlement Agreement. Metric to be measured: Since the last onsite review, of the 20 sections of the Settlement Agreement, there was documentation that the implementation (including inter-observer agreement) and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for ___ (%) of the 20 sections. The Facility was not in substantial compliance with Section E.1, because the plan narrative needed additional work; the matrix needed to include: trend reports for abuse/neglect/exploitation, injuries, unusual incidents and restraints, as well as key indicators and accurate descriptions of the various monitoring tools in use; and a method for documenting assistance provided to discipline heads by PCMs needed to be in place and implemented. In addition, the Quality Assurance Department needed to attend to the other items in this provision that were not fully performing. The Facility had updated the Data Inventory and provided a comprehensive listing of available data. The Facility found noncompliance its Facility Self-Assessment.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	<u>Data and QA Reports</u> Data from the QA plan matrix for none of the 19 (0%) sections of the Settlement Agreement (not section E) were: ▪ Summarized; ▪ Graphed showing trends over time; and ▪ Analyzed across a) program areas; b) living units; c) work shifts; d) protections, supports, and services; e) areas of care; f) individual staff; and/or g) individuals. While there were PCM data summaries for some sections of the matrix (i.e., D, F, I, J, O, P, R, T, U and V) and data was analyzed as to inter-rater agreement, the analysis did not generally show trends over time or across areas. Trend reports (abuse/neglect/exploitation, injuries, unusual incidents, and restraints) were included in the file, as well as in other records. These trend reports summarized data, graphed it over time, and provided some analysis. However, there was little narrative or recommendations in the reports. The recently instituted Combined Trend Report was available and showed promise in its analysis of data from several sources (abuse/neglect/exploitation, restraints, injuries) by	Noncompliance

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		individual, by home, by shift, by location, etc. What was needed were comments on the identified trends and recommendations for action to be taken. A key to making this process useful is that data must be presented over time for a long enough period to permit assessment of trends; graphs need to present data in ways that facilitate analysis; and the analysis should result in the identification of common issues and/or underlying causes of those trends or issues. <u>Regular Meetings Between Discipline Department and QA Staff</u> The QA Director and the PCMs reported that most met monthly to reconcile findings on samples and to discuss any issues that emerged or that disciplines asked to discuss. However, minutes of the meetings were not being kept. The PCMs' Quarterly Data and Summary Reports, while not minutes of meetings, were indicative of meetings having been held. Such reports were found for sections: D, E, F, I, J, O, P, R, S, T, U, and V within the last quarter. <u>Review QA Related Actions</u> Based on a review of a sample of five of the sections of the Settlement Agreement (i.e., C, D, J, T, and U), none had minutes of meetings between QA staff and discipline heads. However, based on documentation in the PCM monitoring summaries, the discussions with PCMs, and analyses of data where available: ▪ In the October 2013 to March 2014 period, a meeting occurred at least once for four of the sampled sections (80%) of the Settlement Agreement, and all of the five topics listed below were included in none of them (0%). The one section that did not appear to have a summary was Section C. o In 0%, review of the data listing/inventory and matrix; o In 80%, discussion of the data and outcomes (Section C was the exception); o In 100%, review of the conduct of the self-monitoring tools; o In 60% (D, J, and T) creation/proposal of action plans or corrective action plans; and o In 0%, review of previous corrective action plans. <u>Data were available</u> In the last quarter, in three of the five (60%) summaries, data were available to facilitate department/discipline analysis of data. As noted, however, this finding was based on discussions with PCMs and limited information in files in the absence of meeting minutes. The two that did not have data available were Section C, where no summary was available and Section D, where the summary included only the PCM data.	

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		Data were reviewed/analyzed ▪ In three of the five summaries (60%) data were reviewed and analyzed. Those three were for sections J, T, and U. Section C was not available and Section D did not include the Section Lead's data. ▪ In the sampled summaries, none of the five (0%) included discussion of action plans and no CAPs were created for systemic problems and for individual problems, as identified. QA Reports The QA Plan required a monthly report on the results of monitoring. It was not clear from the plan whether the monthly QA report was to be done by the QA Director or whether it was intended to be individual reports on each section compiled by the Section Leads and/or the QA Director jointly, or whether it was to include separate reports on each section by both the QA Director and the Section Lead. Since the last onsite review, QA reports (for dissemination at the Facility and for presentation to the QA/QI Council) were created for six of the six (100%) months. However, the QA reports were quarterly presentations by the Section Leads with some additional reporting by the QA Director. It was not clear that the information provided in PCM data and summaries was included in the section reports to QA or covered by the QA Director in separate reports. Of the 20 sections of the Settlement Agreement, 20 (100%) appeared in a quality assurance section report to QA/QI Council at least once in each quarter since the last onsite review. Of the sections of the Settlement Agreement that were presented, 0 of 20 (0%) contained the following components: a. Self-monitoring data i. Reported for a rolling 12 months or more; and ii. Broken down by program areas, living units, work shifts, etc., as appropriate; b. Key indicators i. Reported for a rolling 12 months or more; and ii. Broken down by program areas, living units, work shifts, etc., as appropriate; and c. Narrative analysis. Facility QA/QI Council Design: There was an adequate description of the QA/QI Council in the QA plan narrative. Schedule, agenda, attendance	

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		Since the last onsite review, the QA/QI Council met at least once each month. Minutes from 18 of the 18 (100%) of the QA/QI Council meetings since the last review indicated that the meetings occurred according to schedule or were delayed by the presence of a holiday. Minutes from 18 of the 18 (100%) of the QA/QI Council meetings since the last review indicated that the agenda included relevant and appropriate topics. A sample was drawn of two meetings, one in October (10/2/13) and one in November (11/21/13) and attendance was checked against the list of 15 core members that were required to attend according to the QA Plan. In each case, from three to five of the 15 core members were missing, usually the Director of Food and Nutrition Services, the Director of Maintenance/Plant Operation, the Medical Director, and the Director of Risk Management. Generally, from 67% to 80% of the core team members were present. As a result, minutes from none of the two sampled (0%) of the QA/QI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. <u>Data and Analysis Presented</u> Minutes from none of the 18 (0%) QA/QI Council meetings since the last review documented that: a. Data from QA plan matrix (key indicators, self-monitoring) were presented; b. The data presented were trended over time; and c. Comments/interpretation/analysis of data were presented. However as noted in other parts of this report, trend reports for abuse/neglect/ exploitation, injuries, unusual incidents and restraints were available and trended over time, providing considerable data, graphed for ease of use, and with some analysis provided, but did not include interpretation in the form of a narrative or recommendations as to how the results might become CAPs or otherwise be addressed. <u>Recommendations and Corrective Action Plans</u> In none of the 18 meetings (0%), recommendations and action plans were selected when appropriate to do so and were based on the data presented. While meeting minutes referenced action plans and proposed action plans, it appeared that: ▪ Only four CAPs emerged during the six months (September to March) since the last review as evidenced by the list of CAPs presented and being tracked. ▪ Data across most sections indicated areas that could have been considered for CAPs as evidenced by the results of QA Monitoring reports and the fact that not all sections of the Settlement Agreement were in substantial compliance.	

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Two CAPs emerged from workgroups; one appeared to result from a staff vacancy and the fourth from reviewing data from the monitoring tool.
Corrective Actions and CAPs
<u>System for generating CAPs:</u>
A written description did not exist that indicated how CAPs were generated, including the criteria for a CAP and a description of how to evaluate indicators for criteria.

<u>CAP development</u>:
When considering the full set of four CAPs developed since the last review, none (0%) appeared to have been chosen following a written description policy or procedure. Each had a source for the issue such as the Monthly Monitoring Tool, or the QA/QI workgroup.

<u>Content of each CAP:</u>
A sample of the four CAPs that were generated since the last review were selected, including:
<table>
<tr><th>Sample ID #</th><th>Date of CAP</th><th>Listed as:</th><th>Topic</th></tr>
<tr><td>E1</td><td>12/3/13</td><td>Community outings…</td><td>Increasing SAPs for community outings from 26% in October and 46% in November to 80%</td></tr>
<tr><td>E2</td><td>1/24/14</td><td>Refusals</td><td>To have a representative from the QIDP, Behavioral Health Services, and residential services in the ICST meeting and thereby improve communication between the ICST and IDT.</td></tr>
<tr><td>E3</td><td>9/18/13</td><td>Inconsistent data…</td><td>A single source for data for Section I.</td></tr>
<tr><td>E4</td><td>1/24/13</td><td>Family participation in education re: living</td><td>To determine how to encourage family participation in education re: living</td></tr>
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		options	options.

Three of the CAPs in the sample were completed CAPs and one was a current/ongoing CAP. While there were incomplete CAPs at the conclusion of the last review, none of those was presented as still being tracked. The four in the sample were numbered for ease of reference.

Of the four CAPs the Monitoring Team reviewed, two (50%) appeared to address the specific problem for which they were created. Those that did not included:

- Sample #E3: This appeared to be a CAP to develop a CAP, having each Section Lead provide a list of databases and/or spreadsheets that they were populating to QA/QI with the name of the person doing their data input in order to identify the sources for data and the most effective way to assemble those data. The expected outcomes were not clear, and it was not clear why the authors were not exploring the existing data inventory to help decide where to acquire the needed data.
- Sample #E4: The issue appeared to be that families were not participating in education about living options. The one-step CAP included emailing a request to one sister organization to learn how that Facility was encouraging family participation. There were no data on what participation was at CCSSLC (i.e., a baseline), nor any data on an expected outcome.

<u>CAPs contained all necessary components</u>

Based on a sample of four CAPs, which represented 100% of the total of four CAPs since the last review:

- Two (50%) included the actions to be taken to remedy and/or prevent the recurrence. Samples #E.3 and #E.4 had action steps, but it was not clear how those steps would lead to an efficient data format for Section I (#E3) or to an increase in Family participation without additional actions (#E.4)
- Three (75%) listed expected outcomes for each step in the CAP. The one that did not was #E.1, which had what appeared to be an overall expected outcome, but did not list outcomes for each step.
- Two (50%) listed a person responsible for each step. The two that did not were:
  - #E.1, where there was a list of positions responsible for the entire CAP with no clear indication of who was in charge of ensuring the CAP was carried out; and
  - #E.3, where "all Section Leads" was entered for four of the five steps in the CAP. Such designations do not make clear who has the ultimate responsibility for the CAP. Without specified responsibility, results exemplified in the CAP #E3 occur, where there was no follow-through on any of the steps resulting in extensions due to failure to disseminate.

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		▪ All (100%) included the timeframe in which each action step was to occur. Based on the review conducted that found inconsistent reviewing, analyzing and presenting data; unclear linkage between data analysis and the corrective action plans; insufficient action steps in CAPs; the unclear designations of responsibility; and the unclear outcome measures to evaluate the success of the CAPs, the Facility was not in compliance with this provision of the Settlement Agreement. The Facility made similar findings in the Facility Self-Assessment.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a sample of four CAPs, which represented 100% of the total of four CAPs, disseminated since August 2013, there were: ▪ Three (75%) that included documentation about how the CAP was disseminated, though the name of the CAP or identifying information about the CAP was not clear from the information provided. On 9/19/13, the QA Director disseminated sample E3 via email. However, the copy list did not include all those listed as responsible on the CAP. ▪ Four (100%) that included documentation about when each CAP was disseminated; and ▪ Three (75%) that included documentation indicating to whom the CAP was disseminated, including specific person(s) responsible and attached the CAP. #E3 was the exception since the list of who received the CAP did not include everyone listed as responsible. In addition, the CCSSLC Tracking Sheet provided in response to Document Request TX-CC-1405.IV.10 indicated that for Sample #E3: "The Section Lead requested an extension from the QA/QI Council due to the ineffectiveness of the dissemination process to all parties." Facility Procedure E.10, revised 5/24/12 indicated that the: "Center Lead will implement, disseminate responsibilities and include the QA Director in the dissemination process…" This appeared to be an awkward process. While the QA Director listed the dates of dissemination of four CAPs in the self-assessment, producing evidence of dissemination took additional time and effort and evidence could not be produced that Sample #E3 had been disseminated to all listed as responsible. The Facility was found to be in noncompliance with this provision, since one of the four CAPs was not disseminated to all responsible parties. The Facility found substantial compliance in their Self-Assessment. At the next review the Facility should have assembled and be prepared to produce documentation of dissemination of CAPs initiated since February 1, 2014 that includes: 1) the CAP; 2) how it was disseminated; 3) when it was disseminated; and 4) to whom it was disseminated, including the persons listed as	Noncompliance

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		responsible for the CAP.	
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	Implementation of CAPs Based on a sample of three completed CAPs and one ongoing CAP (i.e., as identified in the table included in relation to Section E.2), three (75%) were implemented fully and three (75%) were implemented in a timely manner. The one that was not fully and timely implemented included: ▪ Sample #E3, where the date of implementation was delayed and had to be rescheduled, due to ineffectiveness of the dissemination process to all parties involved. It was not clear from the tracking sheet what the revised dates were or whether anything at all had been done on any of the steps. Tracking CAP status There was a system for tracking the status of CAPs, which consisted of a column on the tracking sheet for comments/additional recommendations/actions. Of the four CAPs in the sample being tracked by the Facility, for none (0%) did the tracking sheet indicate the status of the CAP and any action taken if a CAP had not been implemented. ▪ Sample #E1 noted that all steps were completed on the same day though the steps appeared to be independent of each other and appeared to have varying target dates for implementation. For example: two steps involved training bus drivers on 12/12/13. Another involved getting trip packets made for outings. The Tracking Sheet indicated that both were completed on 1/21/14. ▪ Sample #E2 had dates due, and noted some dates accomplished in the comments columns. But it was not clear, for example, whether the step to conduct weekly program reviews was completed because the process was in place or whether the reviews had achieved the expected outcome of "improving the quality of monthly data." ▪ Sample #E3 had not achieved any of its due dates because of problems with dissemination. However, there did not appear to be any new dates established. If the due dates on the sheet were actually the new dates, then there should have been some explanation in the comment section about what had been accomplished by those dates. ▪ Sample #E4 had a note indicating the step had been completed (contact had been made with another Facility to explore options), but it was not clear how accomplishment of that one step would achieve a solution to the stated issue (limited family participation in education regarding living options.) Management of CAPs The Facility QA Director: ▪ Did maintain summary information/data regarding CAPs and their status (number of CAPs and number overdue) that was updated within the month prior	Noncompliance

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		to the onsite review in the sample of CAPs; and ▪ Did present this information to QA/QI Council at least quarterly. The Facility was not in substantial compliance with this provision. The Facility also indicated a finding of noncompliance in their Self-Assessment.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	<u>Evaluate effectiveness of CAPs</u>: The QA Director did not have a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification. Once a system is developed, based on a review of a sample of CAPs, the following metrics will be used to assess the Facility's compliance: ▪ For ___out of ___CAPs (%), documentation showed review of their effectiveness (i.e., outcomes), and for ___out of ___CAPs (%), documentation showed review of their timely completion. ▪ Of the ___ CAPs that appeared to need modification, ___ (%) were modified. ▪ Based on a sample of ___ completed CAPs and ___ in process CAPs, ___ (%) were discussed at QA/QI Council. ▪ For ___ out of ___ (%) modified CAPs, evidence was present to show timely implementation. ▪ For ___ out of ___ (%) modified CAPs, evidence was present to show full implementation. CCSSLC was not in substantial compliance with this provision. The Facility reviewed "data related to CAPs" to determine that this provision was not in substantial compliance in its Facility Self-Assessment. No data was presented to the Monitoring Team as evidence that the requirements of this provision were satisfied. To move toward substantial compliance with this provision the Facility will need to: ▪ Show that the outcome for each CAP is measureable and provide evidence that it was measured; ▪ Show that, as appropriate, the QA/QI Council recognized the need to modify a CAP through its minutes; ▪ Show that each step of the CAP was completed timely, or an extension was requested and approved; and ▪ Document that the CAP was completed and when/how the outcome was checked to be certain it was having the desired effect.	<u>Noncompliance</u>

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section F; o CCSSLC Self-Assessment for Section F, updated 3/14/14; o Action Plan for Section F; o CCSSLC Provision Action Information for Section F; o A list of Qualified Intellectual Disability Professionals (QIDPs) who have been deemed competent in meeting facilitation; o CCSSLC QIDP Listing with current caseload totals, undated; o DADS SSLC Policy Number 004.2, effective 11/21/13; o CCSSLC Integrated Protections, Services, Treatments and Supports policies revised since last review, including: ▪ CCSSLC Policy #004.2: Individual Support Plan Process, implemented 11/22/13; ▪ F.10 – ISP Monitoring/Monthly Review Process, implementation 2/6/14; and ▪ F.22 – Programming Review Committee (PRC), implementation 10/4/13; o Monitoring tools used by the Facility to assess the quality of the ISP and ISP meeting, and reports issued with findings and recommendations; o Last 10 monitoring tools completed by the QIDP Coordinator, various dates; o Last 10 monitoring tools completed by the Quality Assurance Department Staff, various dates; o I-Learn Individual Support Plan Cycle, CCSSLC, dated 2/20/14 o Supporting Visions: Person-Centered Planning, dated September 2012; o New Employee Orientation training for Section T Policy: Most Integrated Setting Practices; o Q Construction: Facilitating for Success, undated; o Settlement Agreement Cross Referenced with ICF-MR [Intermediate Care Facility for Persons with Mental Retardation] Standards Section F – Individual Support Plan Meeting and Documentation Monitoring Checklist; o Review tools and aggregate data from the Program Review Committee, various dates; o CCSSLC Individual Support Plan checklist, undated; o For the last year, aggregate data summary reports on assessments completed for ISPs, including timeliness; o A list of individuals admitted to the Facility since the last review, including the date of their admission and the date of their initial ISP meeting; o List of individuals with most recent ISP date, previous date, and date of filing, for 2/1/13 to 1/31/14; o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda (ISPAs), Integrated Risk Rating Forms (IRRFs), Integrated Healthcare Plans (IHCPs), Preferences and Strengths Inventory (PSI), Rights Assessments, Community Living Options Information Process (CLOIP) worksheet or most recent Permanency Plan, skill

	acquisition and teaching programs, the last three monthly reviews, individual's daily schedule, Special Considerations list/Individual Profile Sheet, ISP Preparation Meeting documentation, and documentation of training for direct support professionals on the ISP, including all related components (e.g., PBSP, IHCPs, SAPs, etc.), and indication of percentage of direct support professionals assigned to work with the individual who have been trained for the following: Individual #159, Individual #285, Individual #141, Individual #297, Individual #296, Individual #298, Individual #359, Individual #146, Individual #310, and Individual #77; o For individuals in the sample, the spreadsheets showing: a) attendance at the ISP meeting; and b) assessment submission; and o Handouts from Assessment Review Committee on 4/2/14. ▪ **Interviews with**: o Rachel Martinez, QIDP Coordinator; and o Kimberly Benedict-Rodriguez, Director of Education and Training. ▪ **Observations of**: o ISP meeting for Individual #184, on 3/31/14; o ISP meeting for Individual #91, on 4/1/14; o ISP meeting for Individual #268, on 4/2/14; and o Assessment Review Committee, on 4/2/14.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 3/14/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section F, in conducting its self-assessment: ▪ The Facility was not using a monitoring/auditing tool. Based on discussion with the QIDP Coordinator, different audits were completed for the Self-Assessment for Section F than for the internal quality improvement functions. It appeared that this was due to the need to complete the indicators that State Office required for Section F for the Self-Assessment, and the Facility's recognition that different indicators would be more helpful. Based on this discussion, the Facility had developed/revised audit tools for its internal quality improvement processes, but the data from these efforts were not used in conducting the self-assessment. Rather, the QIDP selected another sample of ISPs for the self-assessment process, and did not use an audit tool, but just collected the information needed to fill in the State Office indicators for Section F. It is not a good use of staff's time to conduct separate audits for these two purposes. The self-assessment function is one that should outlive the Settlement Agreement, and should be functional for the Facility. The Facility should work with State Office to develop an audit process the results of which can be used for both the Self-Assessment and internal quality improvement processes. ▪ The Self-Assessment identified the sample(s) sizes. Generally, this included the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size).

	▪ The following staff/positions were responsible for completing the audit for Section F of the Self-Assessment: the QIDP Coordinator. As a result, inter-rater reliability could not be established at the Facility. It was unclear if State Office had made any attempt to establish inter-rater reliability across the 13 Facilities. ▪ The staff responsible for conducting the audits/monitoring had not been formally deemed competent in the completion of the Self-Assessment activities. Although the staff responsible had experience with developing and implementing ISPs, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. ▪ The Facility used other relevant data sources. For example, the Facility maintained a database to track the timeliness of assessments, as well as spreadsheet to track attendance at ISP meetings. The QIDP Coordinator tracked the QIDPs that had been deemed competent in facilitation. Some of this information was included in the Self-Assessment. ▪ The Facility presented some of the data in the Self-Assessment in a meaningful/useful way, but improvements were needed in some areas. Specifically, on a positive note, the Facility's Self Assessment for Section F: o Consistently presented findings based on specific, measurable indicators. Areas requiring improvement included: o The Self-Assessment did not include indicators that consistently measured the quality as well as presence of items. It was not consistently clear whether or not the quality of the ISPs was being assessed. For example, it was unclear if issues related to the quality of assessments (e.g., not just listing preferences, strengths, and needs, but addressing them meaningfully), or the quality of team's discussion and recommendations related to community living options had been assessed. ▪ The Facility rated itself as being in compliance with none of the subsections of Section F. This was consistent with the Monitoring Team's findings. ▪ In many cases, the Facility data's identified areas in need of improvement. On a positive note, the Facility's Self-Assessment for Section F consistently referenced the action plans, including specific steps within action plans that the Facility was implementing to address issues identified. This should assist in "closing the loop" to show that data that identify problems are acted upon.
	Summary of Monitor's Assessment: Since the Monitoring Team's last review, the following were some of the most positive developments: ▪ The Facility developed and was implementing the Assessment Review Committee. Based on observation during the week of the onsite review, the Assessment Review Committee provided a valuable forum to effectuate improvements in specific components of assessments. The Committee used a peer-review format, and a specific audit tool was used to guide the discussion and provide feedback to team members. During the meeting observed, the group addressed the clear identification of needs, the incorporation of individuals' preferences and strengths, and improvements in the quality of recommendations, which were all changes that are necessary to facilitate the development of comprehensive and effective ISPs. According to the policy that set forth the purpose and format for the meetings, the Committee also would look at the goals recommended in assessments and barriers to reaching the goals. Overall, this Committee was a

	positive addition that should assist in improving the quality of assessments. ▪ Since the last review, CCSSLC had revised its ISP Monitoring/Monthly Review Process policy. This revised policy shifted the focus to integrated monthly reviews, and included roles for team members other than the QIDPs, including, the RN Case Managers, Residential Coordinators, and the Behavioral Health Specialists. Although this format did not yet cover all of the aspects of the ISP and IHCPs, as the Settlement Agreement requires, it was a significant improvement over the previous format, and included some important components that helped to provide a more rounded picture of the individual on a monthly basis. In addition, the revisions included a cumulative record of the individual's status throughout the ISP year. Based on a review of a sample of monthly reviews that had been completed using the new format, it was easier to quickly see when progress had occurred or was lacking. This should assist teams in determining when action is needed. In order to avoid duplicative work, consideration should be given to combining other monthly reviews (e.g., for Behavioral Health Services), and/or assessments (e.g., the Education and Training annual assessment) with the monthly review process. ▪ Timeliness as well as team attendance at ISP meetings continued to be areas on which the Facility was working to make improvements. The QA/QI Council was regularly reviewing timeliness and attendance data. The following are some of the areas in which concerted efforts were needed to move towards substantial compliance: ▪ Examples are provided in various sections of this report of individuals experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to medical and nursing care, as well as physical and nutritional management supports. Although clearly more work needed to be done, it was positive that the new monthly format drew attention to this issue by including sections on changes of status, as well as Infirmary Admissions and hospitalizations. Improvements in the measurability of goals and actions steps related to the identification of individuals' changes in status and then monthly (and more frequently as necessary) review of this data will be necessary for teams to identify changes of status early and respond accordingly. ▪ Teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences. ▪ Although some limited improvement was seen, ISPs generally continued to lack measurable objectives necessary to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, or maintaining his/her current status). ▪ Different audits were completed for the Self-Assessment for Section F and for the internal quality improvement function. It appeared that this was due to the need to complete the indicators that State Office required for Section F for the Self-Assessment, and the Facility's recognition that different indicators would be more helpful. It is not a good use of staff's time to conduct separate audits for these two purposes. The self-assessment function is one that should outlive the Settlement Agreement, and should be functional for the Facility. The Facility should work with State Office to develop an audit process the results of which can be used for both the Self-

	Assessment and internal quality improvement processes.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	On 11/21/13, DADS State Office issued Policy #004.2: Individual Support Plan Process. On 11/21/13, CCSSLC adopted the State Office policy, and began implementation on 11/22/13. The Facility had continued to update its local policies related to Section F requirements. Comments regarding the State Office policy and Facility policies are included in the subsections to which they apply. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans, CLOIP worksheets, skill acquisition and teaching programs, the last three monthly reviews, individual's daily schedule, Special Considerations list/Individual Profile, ISP Preparation Meeting documentation as available, and training records for direct support professionals. A sample was requested of the most recently developed ISPs from each residence on campus. Therefore, a variety of QIDPs and interdisciplinary teams (IDTs) had been responsible for the development of the plans. A sample of 10 plans was selected from different QIDPs and teams, and included plans for: Individual #159, Individual #285, Individual #141, Individual #297, Individual #296, Individual #298, Individual #359, Individual #146, Individual #310, and Individual #77.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	Progress had been made and/or sustained with regard to the facilitation of ISPs by one person from the team who ensured that members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive developments included: ▪ Policy #004.2 in Section II.F.1.b indicated that the QIDP would assist the individual and LAR, as appropriate, in leading the team in an interdisciplinary discussion. The Facility's Policy F.4: Individual Support Planning, implemented 10/12/12, further defined the role of the QIDP, including activities before, during, and after the ISP meeting. This policy defined the QIDP's role in notifying team members required to attend the meeting of the date and time, as well as the QIDP and Lead QIDP's responsibility for ensuring that necessary assessments were submitted, and if assessments were missing, taking action to obtain them. ▪ The QIDP Coordinator confirmed that QIDPs facilitated the teams, including team meetings. Observations of team meetings and reviews of ISPs also illustrated that the QIDP was the team leader and responsible for ensuring team participation. ▪ An important role of the QIDPs was assisting individuals and their guardians to	Noncompliance

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		participate in the meetings. During the onsite review, in the meeting for Individual #184, the QIDP ensured the individual and guardian's opinions were sought, and that they participated in the meeting. ▪ With regard to staffing, the Facility had a QIDP Coordinator and two Lead QIDPs, as well as a QIDP Educator. At the time of the onsite review, a third Lead QIDP position was in the process of being established. A total of 13 QIDP positions resulted in a QIDP being assigned an average caseload of 18 individuals, with a range of eight to 21. One of the challenges continued to be the turnover in QIDP positions. Since the last review, the QIDP Coordinator reported that three QIDPs had turned over. This represented 23% of the direct-line QIDP workforce. Sometimes, QIDPs were promoted within CCSSLC. Although this was positive for other departments, it resulted in constant retraining of QIDPs. This likely impacted the speed with which the necessary changes could be made in the ISP process. ▪ As is discussed in further detail with regard to Section F.2.e, the Q Construction: Facilitating for Success training was still provided to new QIDPs, and it included a competency-based component. At the time of the most recent review, the QIDP Educator, and two QIDPs had been deemed competent in meeting facilitation. A third QIDP had been deemed competent, but had recently resigned. ▪ Since the last review, the QIDP Coordinator and QIDP Educator attended at least two to four ISP meetings each month. They provided technical assistance to the QIDPs and the teams. Sometimes, this occurred during the meetings, but they also met with teams after the meetings to share more in-depth feedback related to their findings from the monitoring tool. ▪ As discussed in the last report, the Programming Review Committee continued to meet. This was an example of good coordination between the QIDP and Active Treatment Departments. The group met weekly and reviewed two individuals' ISPs and monthly reviews. This Committee offered a respectful peer review opportunity for the monthly reviews and ISPs. It was anticipated that next steps would be establishing inter-rater reliability with the tool, aggregating and analyzing data collected from this process, and identifying and acting on any problematic trends identified. ▪ During the week of the review, the Monitoring Team observed three team meetings, including those for Individual #184, Individual #91, and Individual #268. Progress had continued to occur with regard to the facilitation of meetings. Based on these limited observations and review of ISPs, some of the areas in which progress had continued or begun included: o At annual ISP meetings ground rules were clearly set forth, and the ISP format in the revised policy provided an agenda. o Paper hung on the walls or white boards were used to track key components of the ISP process, such as the individuals' preferences, and	

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		action plans that needed to be developed. o The teams had a more comprehensive discussion than in the past about a wider variety of the protections, supports, and services. For example: ▪ Individual #184's team had good discussion of the causes of his falls and possible solutions. For example, one potential cause was Individual #184 not leaving his seatbelt fastened, and falling forward out of his wheelchair when reaching for items. The team discussed the possibility of developing a reinforcement to increase his use of the seatbelt, and the Behavioral Health Services team member agreed to develop a plan that would utilize intermittent reinforcement. The team specifically discussed incorporating some of Individual #184's preferences into the plan. ▪ The QIDP for Individual #184 facilitated incorporation of various pieces into integrated plans, such as including communication supports with behavioral supports. In addition, as noted above, behavioral supports were included in the plan to address falls. OT/PT supports also were included, because the team believed that another cause of falls might be that he tipped sideways in his wheelchair. OT/PT staff were included in the plan to assess whether widening the base of his wheelchair and/or adding tilted wheels would help. ▪ For Individual #184, the team discussed the Psychoactive Medication Treatment Plan, including the potential and realized side effects. ▪ The team for Individual #268 had good discussions regarding the use of Social Stories in addressing his behaviors of stealing things from others. Information was provided by the SLP regarding the positive outcomes from the past use of a Social Story for dental issues for the individual. ▪ The psychiatrist for Individual #268 brought up a number of important clinical issues regarding Individual #268's medication regimen and his sleep issues. ▪ The team for Individual #268 added a lengthy list of the individual's strengths to the ISP, illustrating that they were very familiar with him. ▪ For Individual #91, the team discussed the content of IHCP at the end of each section of the IRRF and made additions, when necessary. Based on review of ISPs as well as during observations of meetings held the week of the	

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		onsite review, facilitation of team meetings was continuing to improve, but this continued to vary from team to team. For none of the plans reviewed (0%) or meetings observed was it resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, two of the current 13 QIDPs and the QIDP Educator had been deemed competent with meeting facilitation. ▪ Based on limited observations of meetings held the week of the onsite review, areas in which QIDPs will need to obtain full team participation and facilitate meaningful discussion included, but was not limited to: o QIDPs and teams were using some of the necessary data to make decisions in relation to individuals' risk areas, but some important data continued to be missing from these discussions. A number of gaps also continued to exist, for example with regard to teams' discussions about data related to skill acquisition programs, PBSPs, and measurable objectives related to risk plans. o Teams needed to expand the depth of the preferences identified for individuals. QIDPs should continue to challenge teams to define what it is the individual prefers about items such as foods or activities to allow teams to offer the individual new experiences, and to expand the discussion to include preferences related to work, relationships, past experiences, future opportunities, etc. These then should be incorporated into action plans. o Similarly, teams need to identify a comprehensive list of the individual's strengths, and using them to build upon the individual's current independence, relationships, vocational experiences, etc. o QIDPs should continue to challenge team members to offer their expertise in problem-solving or developing action plans, even when the action plan does not fall squarely within their domain. o QIDPs should further facilitate teams' discussion of action plans. o Teams need to ensure that day and vocational options are fully discussed, and plans reflect individuals' strengths and needs and set forth a full day of out-of-home activities, unless justification is provided. o Teams should set forth clearly the methodologies or how outcomes will be accomplished. o QIDPs should focus teams on defining measurable, functional objectives during team meetings. Although progress was seen with regard to measurability and the development of objectives that would inform the team about the individual's status, this continued to be an area requiring focused efforts. o QIDPs should assist teams to articulate meaningful outcomes for	

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		individuals. ▪ The following describes some of the challenges regarding the meetings observed during the onsite review: o Individual #184's team did not discuss measurable goals and objectives to determine whether he was improving, regressing, or remaining stable. This needs to be the responsibility of the entire team, and needs to be done for all of the action plans, including IHCPs. o Although Individual #184 required pre-treatment sedation, the team did not specifically discuss a desensitization plan or other strategies to reduce the need for sedation. o For Individual #184, the team identified that the behavioral data was not accurate. However, the team did not develop a plan to improve the quality of the data. o Individual #91's team did not discuss the inclusion of individual-specific triggers in appropriate risk categories to alert staff to a change in status (e.g., choking, aspiration, cardiac, infections, and urinary tract infections). o A draft copy of the IHCP was not available to IDT members during Individual #91's ISP meeting. o The team for Individual #268 did not integrate most of his preferences and strengths into their overall discussions. Although his preference for tractors, trains, and trucks were frequently acknowledged, most of his other personal preferences and strengths were not included in the discussions. Based on the Monitoring Team's review, progress had been made. However, based on observations as well as review of ISPs, while some meetings were improved, the meetings were not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services. In addition, many QIDPs were not competent in meeting facilitation skills. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. In Section II.A, DADS Policy #004.2 described the interdisciplinary team as including the individual, the Legally Authorized Representative (LAR), if any, the QIDP, direct support professionals, and persons identified as providing services and supports to the individual, as appropriate, including professionals dictated by the individual's	Noncompliance

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	persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	preferences, strengths, and needs and who are professionally qualified and/or certified or licensed with special training and experience in the diagnosis, management and treatment of individuals with intellectual disabilities. Attendance requirements now were determined at the ISP Preparation Meeting held 90 days prior to the annual meeting. As noted in the last report, CCSSLC Policy F.5 included the State Office "Annual ISP Meeting IDT Attendance Indicators" designed to provide teams guidance on this process. Thirty days prior to the scheduled ISP meeting, CCSSLC Policy F.4 on Individual Support Planning required the QIDP to send an ISP Meeting Attendance Memo to notify the team members that they were required to attend the ISP meeting. Since the last review, the QIDP Coordinator had contacted the State Office discipline lead to clarify the requirements related to following the ISP template. The discipline lead clarified that the IRRF could be discussed at the beginning of the ISP meeting, particularly for individuals with complex medical needs. This was helpful in accommodating the schedules of PCPs and other medical staff that might not be able to attend the entire ISP meeting. Based on a review of the Action Plan for Section F and interview with the QIDP Coordinator, monitoring was occurring of ISP Preparation meeting meetings and documentation. The goal was to ensure that IDTs were identifying the IDT members that should attend the ISP meetings, including providing sufficient rationale when a team member's presence was determined not to be necessary. When a complete review of this section is completed, the following indicators will be assessed: Based on the sample of ___ ISPs the Monitoring Team reviewed: ▪ For ___ of ___ (____%), at the ISP Preparation Meeting, the team defined the members of the team that should attend the annual meeting. ▪ ____ individuals had strengths, preferences, or needs that potentially required additional team member participation. For ____ of these ____ individuals (___%), the team had adequately justified why such team members' participation was not necessary. ▪ For ___ individual (___%), the team members the team identified at the ISP Preparation meeting as required attended the meeting. ▪ For ____ of the ___ (___%), it appeared that a duly constituted team participated in the annual meetings. Based on this limited review, Facility staff were conducting audits and providing feedback to teams that should assist in improving the identification of appropriate team members for attendance at ISP meetings. The Facility remained out of compliance with	

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		this provision.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	Progress had been made and/or sustained with regard to the conduct of assessments. Positive developments included: ▪ Teams were now supposed to identify needed assessments at the ISP Preparation Meeting held 90 days prior to the annual meeting. ▪ The State Office had developed an Assessment/Report Schedule – Minimum Requirements, which was an attachment to the revised policy. ▪ As noted in the last report, the Facility had developed a Facility-specific policy, Policy F.6 – Submitting Assessments. It included procedures for saving completed assessments on the shared drive, and completion of the IRRF. ▪ In reviewing a sample of ISPs, generally, teams were requiring a full battery of assessments for each individual. ▪ The Facility staff recognized that the quality of assessments was still having a negative impact on the quality of team discussions and the resulting ISPs. In past reports, the Monitoring Team identified concerns related to assessments' identification and incorporation of individuals' preferences and strengths, the identification of needs, and the quality and comprehensiveness of recommendations. Since the last review, the Facility developed and was implementing the Assessment Review Committee. Based on observation during the week of the onsite review, the Assessment Review Committee provided a valuable forum to effectuate improvements in specific components of assessments. The Committee used a peer-review format, and a specific audit tool was used to guide the discussion and provide feedback to team members. During the meeting observed, the group addressed the clear identification of needs, the incorporation of individuals' preferences and strengths, and improvements in the quality of recommendations, which were all changes that are necessary to facilitate the development of comprehensive and effective ISPs. According to the policy that set forth the purpose and format for the meetings, the Committee, which met twice monthly, also would look at the goals recommended in assessments and barriers to reaching the goals. The plan was to use the data collected to inform the system as a whole, as well as to provide feedback to the assessors present at the meetings. Overall, this Committee was a positive addition that should assist in improving the quality of assessments. Areas of concern included: ▪ The Facility was tracking the timeliness of assessments. Based on the data generated for ISPs meetings held between February 2013 and January 2014, some improvement was noted, but issues continued to exist with regard to the timeliness of assessments from specific disciplines. For example, for the month of January 2014, specific disciplines' performance ranged for 37 to 100 percent	Noncompliance

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		compliance, with an average for all disciplines of 82 percent. In some ways, this was an improvement from February 2013, when the range was zero to 100 percent, with an average for all disciplines of 80 percent. Significant variances were seen with regard to various disciplines. For example, using these two months: psychiatric assessment timeliness increased from zero percent in February 2013 to 100 percent in January 2014, while nutritional assessments decreased from 77 percent to 37 percent. The QA/QI Council was reviewing this data regularly, and efforts were being made to improve timeliness. ▪ As noted in a number of other sections of this report, the Monitoring Team continued to find the quality of assessments to be an area needing improvement. This is discussed in further detail with regard to the sections of the Settlement Agreement that address nursing services (Section M), and vocational, habilitation and skill acquisition (Section S). Some assessments in which improvements were seen included psychology, psychiatry, OT/PT, physical and nutritional supports (Sections O), and speech and language assessments. However, problems were still seen with some of these assessments, particularly with regard to the incorporation of individuals' strengths, preferences and needs. In order for adequate protections, supports, and services to be included in individuals' ISPs, it is essential that assessments identify and prioritize individuals' needs, identify in detail supports currently provided, and incorporate individuals' preferences and strengths. ▪ As discussed in previous reports, assessments also frequently did not include adequate recommendations. Some of the issues noted included no or limited specific recommendations, or an incomplete list of recommendations, and recommendations not oriented to the development of action plans. Based on the sample of 10 ISPs: ▪ For 10 individuals (100%), at the ISP Preparation Meeting, the team defined the assessments that were needed for the annual meeting. ▪ In reviewing the ISPs for 10 individuals, the teams for eight individuals (80%) had identified the comprehensive assessments necessary to identify the individuals' strengths, preferences, and needs, and/or had provided adequate justification for not requiring such assessments. Those that did not were Individual #141 (i.e., no identification of need for vocational/day assessment), and Individual #297 (i.e., no identification of need for APEN for individual with a feeding tube). As noted above, generally, teams identified most assessments as requiring completion. ▪ For one of the 10 (90%) (i.e., Individual #296), the necessary assessments were completed and available to the teams at least 10 working days prior to the ISP meeting. Other individuals had missing or late assessments.	

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		In the past, as part of the ISP process, the Monitoring Team had recommended an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment had begun to be included in the ISPs. However, this often appeared to involve a cursory review of the incidents and allegations. It was not clear that the goal had been met of individuals' teams ensuring that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place and appropriately incorporated into the ISP. Most often, the teams did not adequately analyze the information and/or identify areas in which changes might be made to attempt to reduce the frequency of such occurrences. Some example of concerns noted included: ▪ Although the team identified that Individual #297 had a trend in self-injurious behavior and that three restraints had occurred due to self-injurious behavior (SIB), they simply concluded that she had a PBSP. No review was documented to show the team considered whether or not the PBSP was effective, or whether changes to the PBSP had occurred or were necessary. She also had a trend as victim of peer-to-peer aggression, but the team simply concluded that one of the peers had moved, and the other two had PBSPs. No consideration was given to whether current living arrangements were appropriate, or whether actions were needed to help her protect herself. ▪ For Individual #296, it appeared the team talked about the number of different kinds of incidents. Although no apparent trend was identified, there was no indication that the team determined whether or not any further steps needed to be taken to prevent further injuries. ▪ For Individual #298, although the team discussed the incidents, they did not document meaningful discussion of clear trends. For example, Individual #298 had 32 incidents of peer-to-peer aggression, with 23 of them being with the same individual. Although the team described actions being taken with the other individual (e.g., medication and BSP changes), there was no discussion of other alternatives, such as not having the two women living together. Similarly, she had 42 incidents of SIB, but the team did not discuss this in any detail. Although the team referenced the PBSP's focus on aggression, the team did not discuss, or document discussion of the PBSP's effectiveness in addressing SIB. ▪ The ISP identified the incidents that had occurred, but showed no analysis or action to address potential trends (e.g., seven peer-to-peer incidents in which Individual #310 was the victim). Although some improvements were seen with the quality of some assessments, and teams were consistently using the ISP Preparation Meeting to identify the assessments needed for the annual ISP meetings, concerted efforts of all team members will be necessary to bring the Facility into substantial compliance with this provision. The addition of the Assessment Review Committee was a step forward, and all disciplines are	

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		encouraged to participate in and learn from this interdisciplinary peer-review process.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As indicated in previous reports, although the new ISP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of assessments in the ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ In none of the 10 plans (0%) were all recommendations resulting from assessments addressed in the ISPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it. ▪ As noted above, although some improvements were seen, the quality of assessments was lacking. Of particular concern were the issues related to the recommendations included in assessments. There was a need for assessments to summarize in the recommendations the detailed protections, services, and supports that needed to continue for the individual, as well as changes to support either assessment findings or the need to improve the configuration of services the individual required. To the extent possible, these recommendations should be written in specific, observable, measurable terms to facilitate their inclusion in action plans. Efforts were needed to improve the recommendations included in assessments, as well as to ensure that teams considered, and either incorporated recommendations or provided justification for not incorporating them. The Facility remained out of compliance with this provision.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	Based on information the Facility provided, the following activities had occurred to improve compliance with this subsection: ▪ As discussed with regard to Section F.1.c, the Facility had developed and implemented an Assessment Review Committee. One of the functions of this Committee was to review the recommendations included in assessments related to transition to the community. As noted above, the peer-review format of the Committee should assist in improving the assessments in this regard. This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. Based on the review of the sample of 10 ISPs, the following highlights some of the findings: ▪ In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation about the individual's appropriateness for a more integrated/less restrictive setting. In addition, at the	Noncompliance

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		ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Of the 10 ISPs reviewed, for none (0%), all of the assessments included the applicable statement/recommendation. The assessments that did not include recommendations varied from individual to individual, and included: the Functional Skills Assessment, dental, nutrition, Behavioral Health Services, psychiatry, education and training, audiology, and nursing. Of note, at times the statements that were included either did not follow the State Office format (i.e., frequently the ones included in the SL and psychiatric assessments). Of concern, some assessments showed a lack of understanding of individuals' right to live in the most integrated setting and/or the supports that would need to be in place for an individual to be successful. For example: ▪ For Individual # 159, the Behavioral Health Services Specialist did not appear to have a good understanding of the community options available, or the realities of service provision in the community. The assessor stated: " [Individual #159 is considered to be in good health and a functioning individual who will assist with her daily skills. She is diagnosed with Pica is [sic] this is definitely an issue that must be considered when selecting a group home. A Pica free environment will be ideal for [Individual #159] as she would no longer need a 1:1 supervision providing her with the independence she deserves. She must continue to receive psychiatric services but her PBSP can be exchange [sic] to a psychiatric plan if she moves to a Pica free home." These misunderstandings had the potential to place Individual #159 at significant risk. ▪ For Individual #146, the psychiatry recommendation read: "She might be able to go to a group home where all her needs must be met because [Individual #146] needs 24/7 care. In case she goes to a group home the arrangements must be made especially because of her condition. [Individual #146] is fragile with depression, as well as, possible psychosis in remission. So there is no issue of discharging her in the near future because we have to find a very highly structured environment for her." o For the 10 individuals reviewed, nine individuals' ISPs (90%) included a recommendation from the professionals on the team to the individual and LAR. The one that did not was Individual #285. For only three of these individuals (30%) was adequate justification provided for the Facility discipline members' recommendations (i.e., Individual #298,	

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		whose team recommended transition, but the guardian chose not to pursue transition; Individual #359, for whom court involvement precluded his movement to the community; and Individual #146, for whom the team recommended transition). The following provide examples of inadequate justification for teams' conclusions: ▪ For Individual #159, according to the ISP narrative, the psychiatrist indicated that she could not be supported in a less restrictive setting, and the remaining team members said she could. However, this was not consistent with the assessments themselves. The following indicated she could not be supported in a more integrated setting: medical, psychiatric, and nutrition. These differences were not reconciled. The team concluded that the Facility discipline members "determined that [Individual #159] can be served in a less restrictive setting, but not at this time. This determination is based on Medical issues, [Individual #159] is currently hospitalized." The team was planning for the year, and it was unclear why a hospitalization was justification for not recommending referral to the community. ▪ For Individual #141, the narrative of the ISP indicated that all discipline team members except for medical recommended that she could be supported in a less restrictive setting. Based on review of the actual assessments, audiology also indicated she could not be supported in a less restrictive setting. The discipline recommendation was that she could transition to the community, but there was no description of the team's deliberation, or reconciliation of the discrepancy in team members' opinions. ▪ Based on the summary in the ISP, several assessors indicated they did not believe community transition was appropriate for Individual #297. For example, education and training, audiology, psychiatry, and medical all indicated she should not be referred. However, in summarizing the team's recommendation, the only assessor identified as not recommending community transition was audiology, and no discussion was documented regarding how the team addressed the discrepancies. The team concluded that the Facility discipline members determined that Individual #297 could be served in a less restrictive setting. ▪ In their assessments, all discipline members all indicated that	

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		Individual #296 could be supported in a less restrictive setting. However, they then jointly concluded that: "[Individual #296] cannot be served in a less restrictive setting at this time. This determination is based on discussion during the meeting. The team agrees that [Individual #296's] current living environment is less restrictive than a community setting, as [Individual #296] currently is full routine [level of supervision] and has the ability to come and go as he chooses; this would not be possible in a community setting, as it would pose immediate threats to his safety. The team agrees that currently [Individual #296] lacks the ability to understand the differences in his living environment options. The team agreed that by introducing him to different environments, such as adding him to the LA group home tour list, we can begin to increase his knowledge base in that area, with the hopes of possible referral in the future, when his safety can be better ensured." In addition to being unclear why all assessors said he could be supported in a less restrictive setting, and then changed their minds, it also was unclear why the team believed that supports could not be provided in a community setting to allow Individual #296 to access the community when he wanted to. In addition, the team put no action plans in place to teach Individual #296 better safety skills in the community. ▪ For Individual #310, the team made the referral, but stated: "This determination is based on the fact that a PICA free environment would best meet his needs." In the IRRF, the team repeatedly indicated that his level of restriction of one-to-one staff could not be reduced until he moved to the community to a pica-safe environment. This showed a lack of understanding of community environments, and the ongoing needs of individuals with pica. ▪ The Facility discipline members "determined that [Individual #77] can be served in a less restrictive setting at this time and do not recommend that [Individual #77] be referred for community transition. This determination is based on: [Individual #77] lacks the understanding of community living options." The team that went on to explain that because her action plan from last year had not been implemented as written, Individual #77 had not been adequately exposed to community options. In addition, the team concluded that	

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		Individual #77 "is non-verbal and is unable to indicate where she would like to live." The team included no methodologies in the action plan to determine Individual #77's preferences, and her Rights Assessment indicated that she did not have the ability to make informed decisions in any of the areas covered. As a result, although it was important to try to determine her preferences, the team acknowledged that she did not have the ability to make the decision on her own. As a result, the team and/or Facility Director needed to make the decision. ○ In nine of the ten (90%) ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included. For Individual #285, the team did not specifically state a full team recommendation (i.e., none listed). However, of these, four (44%) included appropriate justification (i.e., Individual #141, Individual #298, and Individual #297, whose teams recommended transition, but the guardians chose not to pursue transition; and Individual #359, for whom inquiry had been made of the court, but the court indicated he could not be transitioned to the community). Examples of concerns included: ▪ For Individual #159, the final recommendation was not to refer due to her hospitalization, but no specifics were provided regarding why she could not be referred just because she currently was in the hospital. ▪ As discussed above, Individual #296's team did not recommend transition, but provided inadequate justification, and he did not have a guardian. ▪ For Individual #146, the final recommendation was not to refer her due to her lack of understanding. However, the team had not fully implemented the previous year's plan, did not include in this year's plans an individualized approach to determining her preferences or the methodology to do so, and in her Rights Assessment indicated she could not make programmatic decisions. As a result, it did not appear she would be able to make this decision on her own, and the team did not identify a way for them to get the best sense of her preferences quickly, and move forward with a decision. This was similar for Individual #77. ▪ For Individual #310, as noted above, the team made a referral, but it appeared to be based on a lack of understanding of what the community system could provide for an individual with	

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		pica. ▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such obstacles. In summary, teams were identifying obstacles, but the lists were not consistently complete, including the identification of the specific reasons for the LAR's choice not to pursue transition to the community. Action plans generally had been developed, but they were not sufficiently individualized. Although team members generally were including statements in their assessments with regard to individuals' appropriateness for community transition, and making recommendations to the individuals and/or LARs, these recommendations often were not justified. When disagreements were noted amongst assessment recommendations, their resolution was not consistently explained. The identification of and plans to overcome obstacles to transition were not yet adequately addressed. The Facility remained out of compliance with this provision.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. DADS Policy #004.1 at II.F.4 indicated that action plans should be based on the individual's preferences, strengths, and needs. The policy further indicated: "The IDT must have a comprehensive, integrated discussion with input from each team member on how he or she will formally or informally support the prioritized action plans." The policy included considerable detail regarding the types of action plans teams should	Noncompliance

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		develop (i.e., skill acquisition plans, participation objectives, service objectives, and specific objectives to address individual risk factors), the content of action plans, and topics that action plans should cover. It also required teams to "consider every opportunity for community integration," as well as ensure that "Outcomes and objectives are expressed in terms that provide measurable indices of performance…" On 11/21/13, CCSSLC had adopted the State Office policy. <u>Identification and Use of Individuals' Preferences and Strengths</u> As noted in the last report, teams were making efforts to identify individuals' preferences. Teams at CCSSLC continued to utilize the Preferences and Strengths Inventory. Based on review of the sample of 10 ISPs: ▪ All 10 of the ISPs reviewed included a listing of individuals' preferences and strengths. As the Monitoring Team's previous reports have noted, most of the preferences identified for individuals related to items, food, or activities. Some teams had begun to include some preferences and strengths related to environments, work, relationships, past or future experiences, routines, interactions with others, etc. (e.g., in addition to skills, "such as independent at work," the team for Individual #296 identified a number of strengths that related to qualities of the individual, such as "very kind," "good sense of humor," and "interacts well with others," or for Individual #310, "pleasant disposition, hard worker"). It will be important for teams to continue to expand these lists and define what it is the individual prefers about them to be able to offer the individual new experiences based on this information. ▪ None of the individuals' teams (0%) had effectively incorporated their preferences into related action plans. Often, teams used preferences as a continuation of what the individual already was doing (e.g., interacting with family, or engaging in preferred leisure activities), as opposed to as a way to expand the individual's opportunities. Occasionally, teams made use of preferences to expand an individual's opportunities, but even in the ISPs where some of this was seen, it was not pervasive. For example, Individual #359 indicated he liked animals. The team developed a SAP related to going to pet store and pricing animals. ▪ None of the individuals' teams (0%) had effectively incorporated their strengths into related action plans. Strengths were not regularly built upon to address other need areas. Occasionally, teams incorporated a preference and/or strength meaningfully. For example, the team for Individual #77 developed a goal for Individual #77 to use the remote to turn on the TV. The ISP indicated TV as a preference, and her ability to grasp items was listed as one of the individual's strengths.	

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		<u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> Based on a review of sample ISPs and ISP Preparation Meeting documentation: ▪ None of the plans reviewed (0%) included a list of priority needs. ▪ In none of the plans (0%) was an explanation provided of how the team had determined which supports or training needed to be prioritized over other needs. ▪ In none of the 10 ISPs reviewed (0%) were barriers identified and addressed. Although anecdotally, teams were concerned about lack of staffing or transportation to address individuals' needs, careful delineation of barriers to addressing needs was generally not found. Moreover, teams sometimes cited individuals' behaviors or attitudes as preventing them from participating in activities (e.g., work), but teams had not clearly defined such issues as barriers, and/or implemented plans to address them. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on a review of individuals' ISPs: ▪ Eight of the 10 ISPs (80%) included specific skill acquisition action plans for implementation in the community. The ones that did not were the ISPs for Individual #159 and Individual #310. For Individual #310, no community SAP was included in the ISP. For Individual #159, there were no community SAPs according to the ISP, but then a SAP was included in the documentation to increase her participation in community activities. Other concerns noted included: o For Individual #285, the only SAP or action step designed to encourage community participation was one related to choice making, and review of the actual SAP showed that although it was supposed to occur on "the bus," the activities offered for choice-making did not appear to consistently exist in the community (i.e., "spending time in the hallway"). o For Individual #296, it was unclear how functional the community SAP was. He had a SAP to count magazines in a store once weekly. ▪ Three of the 10 individuals' ISPs (30%) (i.e., Individual #159, Individual #141, and Individual #310) included at least one other measurable objective to enhance individuals' participation and integration into their communities. Even for these individuals, problems included very limited expectations regarding community involvement (e.g., for Individual #159 and Individual #141, the only objectives related to community integration were monthly community visits with no specification of activities or individualization), or objectives or action steps that could be implemented either at the Facility or in the community, which resulted in no commitment to ensure the individuals were involved in the community (e.g., Individual #310, for whom the only action step was to be	

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		involved in preferred activities in "the home and in the community" on a daily basis. Although the narrative of the ISP indicated that he would go to school football games, and go with one friend on the bus to locations in the community, these action steps were not included in the action plans). In addition, none of the community-related objectives were written in a manner to actually encourage the integration of individuals with nondisabled peers and/or the expansion of individuals' experiences in the community. Although CCSSLC had made some progress, the Facility remained out of compliance with this provision. Although teams were identifying some preferences and strengths of individuals, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals' needs was not evident in the ISPs or ISP Preparation Meeting documentation reviewed. As is discussed in the subsections below, individuals' needs were not comprehensively addressed in action plans. Most of the ISPs reviewed had action plans that addressed community skill acquisition, but they generally did not encourage participation in the community with nondisabled peers.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	The action plan section of the ISP and IHCPs were where measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports were to be detailed to attain identified outcomes related to each preference, meet needs, and overcome identified barriers to living in the most integrated setting appropriate to the individual's needs. In the last report, the Monitoring Team reported that the Habilitation Therapies Director developed and provided training on the "At Risk" Process: the IRRF and IHCP. Based on review of the section of the training related to IHCP action plans, it provided some good information about what teams should think about when developing an action plan, such as the etiology of the problem; steps that can be taken, including action steps related to prevention, direct intervention, and training; measurable data that can be collected to assess efficacy; incorporation of key elements of free-standing plans (e.g., PNMP, BSP, etc.); and making plans measurable by answering the who, what, where, and when questions. In August 2013, the training was completed for all IDTs. This was good training, but based on review of the most recent ISPs, QIDPs, RN Case Managers, and other IDT members required additional mentoring on the development of comprehensive and measurable action plans. The following summarizes the findings related to action plans for the sample of 10 ISPs: ▪ None of the 10 plans reviewed (0%) included a full complement of individualized goals or objectives and/or strategies to address the array of	Noncompliance

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		supports and services the individual required. ▪ None of the 10 plans (0%) included a full set of measurable objectives. ▪ This negatively impacted the intensity of individuals' active treatment and habilitation, the supports they were provided, and the teams' ability to measure progress, or lack thereof. ▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, action plans generally had been developed, but they were not sufficiently individualized. The following summarizes concerns related to action plans: ▪ As noted in the last monitoring report, ISPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. Clearly, efforts were being made to make them more measurable. For example, in some cases, ISP Action plans and IHCPs included objectives to allow the team to determine whether the individual was improving (e.g., for Individual #159, "will maintain oral hygiene rating of fair or better," or "maintain adequate hydration AEB [as evidenced by] BUN levels ranging from 5 to 20 at protocol labs;" for Individual #285, will maintain patent airway and clear lung sounds AEB O2 [oxygen] saturation above 95% on room air and no adventitious lung sounds upon auscultation" with an action step for quarterly oxygen saturation readings, although it was unclear if this measurement of lung oxygen saturation was frequent enough, and no measurement was included for lung sounds; for Individual #141, "will have a bowel movement every 2-3 days," or "will maintain her weight within her weight range of 95-120 lbs. [pounds] over the coming year;" Individual #296, "will have an improvement in his OHR [oral health rating] from poor to fair by the next visit"). However, all plans in the sample included goals and objectives that could not be measured (e.g., for Individual #159, "Review effectiveness of psychiatric medication monthly" without providing a goal or definition of what would be considered "effective," or "Review weights, % of meals eaten, and concerns with eating in wt [weight] clinic" without expectations for increases in weight per month; for Individual #285, "will continue participating in Day Programming where he can choose activities of his preference;" for Individual #141, no baseline or specific goal was set to measure: "will maintain a stable cardiac status, weight and blood pressure readings and lipid levels over the coming year;" for Individual #296, "Maintain BP within individually acceptable range," without delineation of what that range was). ▪ Action plans in ISPs continued to include skill acquisition plans. Integrated	

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		Health Care Plans were being developed. Infrequently, PBSP objectives were included, but often only a reference was made to implementation of the PBSP. Similarly, PNMPs, psychiatric plans, and plans to reduce restraint use were noted as having been "approved" in the ISP narrative, but they were not incorporated into the ISP through the inclusion of measurable goals or objectives (e.g., Individual #297 has a psychiatric treatment plan and BSP, but measurable objectives were not included, for example, "PBSP" was an action step; although Individual #310 had a BSP, no specific goals were included in relation to his BSP. More specifically, the goal for the Behavioral Health risk was: "will have a decreased risk of compromise from Pica behavior." In addition to not being measurable, it did not reflect the target behavior goal or replacement behavior goal from the BSP. The action step from the IHCP for behavior read: "BSP to train [Individual #310] on edible items that are safe for ingestion." This also was not measurable). ▪ The action plans teams' developed to address individuals' risk areas generally did not include adequate measurable clinical indicators. This is discussed in further detail with regard to Section I of the Settlement Agreement. However, the lack of these clinical indicators resulted in teams not having a mechanism to measure whether the person was progressing, declining, or remaining stable. Although it was clear the teams were trying to improve in this area, further work was needed to assist teams in identifying adequate, measurable clinical indicators (e.g., goal for blood pressure or parameters for notification of PCP) or outcome measures (e.g., objective for reduction in target behavior or increase in replacement behavior). In addition, teams should consistently identify parameters for when direct support professionals or nurses need to contact the nurse or the PCP, respectively, and/or the team needs to meet to ensure changes in status are adequately addressed. Some progress had been made in the expansion of the scope of measurable objectives, and efforts were being made to improve the measurability and individualization of objectives and action steps. However, as the Facility recognized, these remained areas in which significant work was needed. The Facility remained out of compliance with this provision.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Based on observations of meetings and team discussions, and review of ISPs, the following comments are made with regard to the comprehensiveness of ISPs: ▪ Integration of various plans (e.g., PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, medical treatment plans, etc.) in a measurable way into the ISPs, through, for example, measurable objectives was generally not seen. Although the PNMPs were frequently identified in action plans and the team "approved" other plans, such as the PBSPs and psychiatric treatment plans,	Noncompliance

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		no reference was made to the specific plan approved (i.e., by date), and limited, if any, goals/objectives/action steps were included in the ISPs in relation to plans other than PNMPs. ▪ Delineation was not sufficiently clear of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.). The focus tended to be on implementation, and other areas often were missing or not well defined. Frequently action plans simply stated what would happen without detailing all of the steps and the staff who needed to work in an integrated fashion to achieve the stated outcome. ▪ The ISP action plans and IHCPs did not consistently include the supports that the team identified in the IRRF or elsewhere in the ISP. Disturbingly, when supports were discussed as necessary for risk factors rated as low, the team did not include these in action plans. ▪ Rights restrictions were another area in which very limited action plans were identified to assist in potentially reducing the need for the restriction. Although some money management programs were included, most restrictions had no associated plan identified or the plans did not sufficiently address the underlying issue. ▪ In general, individuals' work and day activities, and staffing needs were inadequately defined. ▪ Most plans included reference to skill acquisition plans, as well as service objectives. Skill acquisition plans often were included as overall topic areas that the SAPs would cover or reference was made to steps in a SAP. It was unclear whether once approved, the teams approved the SAPs, and they were incorporated into the ISP through an ISPA. None of the 10 plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. The Facility remained out of compliance with this provision. Work was still needed to develop comprehensive ISPs. Some limited improvements were seen. However, as noted above, teams will need additional coaching and mentoring to fully implement the process and develop ISPs that meet this requirement of the Settlement Agreement.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	The following findings are based on reviews of the sample of ISPs. ▪ For none of the 10 ISPs (0%), action plans included adequate timeframes for completion. ▪ For none of the 10 ISPs (0%), the roles of the persons identified as responsible were clearly defined.	Noncompliance

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		This most recent review showed some improvement, and as noted above, it was clear that efforts were being made to improve the measurability of action plans. However, the following summarizes some of the problems noted: ▪ Often two positions were identified as responsible for the completion of action steps, but it was not clear who was responsible for what. ▪ Although some improvement was seen, the use of terms such as "as scheduled" or "ongoing" sometimes continued to be used as the timeframe for completion or frequency. These generally were not sufficient to make the objectives measurable and/or clearly define staff's responsibilities (e.g., for Individual #297, "The PNMP addresses that all oral/dental care is to be provided by nursing at eye level" did not identify how often oral care would be completed. "Ongoing" was the completion date, and no frequency was provided). ▪ Sometimes no parameters were set for times of day (or shifts), frequency, or length of time. This made it difficult to measure if it had happened as the team intended (e.g., for Individual #141, "Offering her opportunities for walking inside and outside the home for exercise and leisure" with no parameters provided outside of the frequency of "daily weather permitting;" Individual #159 was described as requiring one-to-one supervision, but no schedule was provided, the frequency of weights was not indicated, it was unclear how frequently nursing staff were to monitor the bowel movement log, etc.). ▪ Sometimes, timeframes did not make sense either given the clinical need or the time in which an activity reasonably should have occurred (e.g., for Individual #285, the QIDP and Transition Specialist were given a year to place him on the group home tour list). ▪ In IHCPs, overall goals now sometimes included measurable indicators to allow measurement of an individual's status. However, the methods for measuring or the staff responsible for measuring them generally were not identified. The following was one example of an overall goal with multiple steps, and no delineation of how the outcome would be measured: "[Individual #77] will maintain clear patent airway aeb [as evidenced by] no Reflux episodes, have normal breath sounds, absence of coughing and O2 [oxygen] saturations of >95% RA [Room Air] during the next 12 months." It was not clear who was responsible for determining or documenting if reflux occurred, or the person responsible or the frequency with which oxygen saturation rates or breath sounds would be measured, when this would occur, etc. ▪ Generally, direct support professionals were identified in the action plans as having responsibility for certain components of the plans. For example, when direct support professionals and supervisory or clinical staff were listed as both being responsible for the same action steps, definition was needed of for what the direct support professionals were specifically responsible as opposed to clinical staff. It will be important, though, to ensure that their roles are clearly	

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		defined, as well as the methodologies they should use to implement action steps. With regard to methodologies in action plans: ▪ In none of the 10 plans reviewed (0%) was the methodology sufficiently described for the action plans included. Some of the problems identified included: ▪ Although improvement continued to be seen in relation to the inclusion of the methodology, steps were often missing [e.g., staff were to provide assistance to allow Individual #159 to attend dental appointments, but it was not clear what the assistance would entail; for Individual #159, the details regarding how one-to-one would be provided were not included, such as line of sight, arms reach, etc.; for Individual #159, although an overall goal was that she would gain weight back slowly, how this was to be accomplished was not set forth; for Individual #141, although the team identified that she resisted brushing her teeth, no methodology was described beyond: "Tooth brushing assistance by staff 3 time daily esp [especially] at bedtime as she requires assistance;" for Individual #141, despite the need for TIVA and a fair oral hygiene rating, the IRRF indicated: "She has been referred to Behavioral Services for evaluation for desensitization and deemed not a candidate... Behaviors cause inability to use sharp instruments, to take x-rays, or floss. She can be aggressive, verbal [sic], has excessive movements and is very anxious;" for Individual #141, the only methodologies for the following goal: "will maintain a stable cardiac status, weight and blood pressure readings and lipid levels over the coming year" related to measuring the individual's status (i.e., "annual cardiac consultation and testing including EKG as ordered per PCP," "monitoring of monthly weights and vital signs," and "review of blood studies"). No preventative measures/methodologies were included; for Individual #296, sometimes methods were included, such as using an electric toothbrush to try to improve oral health, but at other times methods were weak, such as those related to osteoporosis, which were either reactive (i.e., responding to falls), testing (i.e., DEXA scan), or providing supplements and adaptive equipment. What were missing were action steps that staff could assist and/or the individual could complete to improve health (e.g., walking, etc.); and for Individual #310, no methodologies were provided for increasing his participation in class, slowing his rate of eating, or increasing his shredding skills]. ▪ Methodologies were often reactive as opposed to proactive. For example, nursing protocols were to be implemented when signs and symptoms of illness were reported, as opposed to using nursing protocols proactively. In addition, most often, the etiology of the healthcare concern was missing, so it was unclear what steps reasonably could have assisted with these risk areas.	

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		▪ In addition, as is discussed with regard to Section I, action plans for individuals identified as being at risk, frequently did not include adequate methodologies to reduce the at-risk factors to the extent possible. The IHCPs set forth plans that were not sufficiently aggressive to either further evaluate and/or address individuals' high and medium risk levels. When an individual is identified as being at risk, teams should develop plans with clinical intensity that corresponds with the level of risk identified. The Facility remained out of compliance with this provision. In addition to better defining the methodologies in action plans, clear timeframes should be established and the roles of various team members should be specified.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	All plans included some practical and functional interventions. In fact, the vast majority of skill acquisition plans identified functional skills to be taught. Some of the teams had clearly tried to identify interventions to expand individuals' independence in a functional manner. Some examples included training on using hand sanitizer, using a seatbelt, library usage, taking care of personal belongings, using a computer to conduct searches to expand leisure activities, calculating earned wages, using the telephone, budgeting, cooking, applying lotion, turning on the television, and adjusting water temperature. However, some goals were still written in the ISP as "by demonstrating task analysis steps 1-6..." As a result, the functionality could not be determined. In addition, some were vague, making it difficult to determine functionality (e.g., "improving participation skills). However, none of the 10 plans reviewed (0%) effectively addressed the individual's full array of needs for services and supports. Such issues are discussed elsewhere in this report with regard to plans to address conditions that placed individuals at-risk, psychiatric treatment plans, medical care plans, nursing care plans, OT/PT treatment plans, and PBSPs, as well as the lack of sufficient methodologies, as discussed above. In addition, as noted in previous reports, due to some of the characteristics of the Facility at the time of the review, providing training in areas that would be functional in the community, as well as at the Facility, was difficult. For example, some of the goals and objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. A couple of the plans reviewed included a goal related to cooking, but these goals were implemented in a cooking class. Generally, the plans did not include goals related to housekeeping or yard work, which would be typical activities for independent adults. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at CCSSLC, skills that individuals	Noncompliance

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		were learning or practicing daily on campus were not practical or functional in the community. In addition, many individuals at the Facility had part-time schedules for work or day activities, and teams did not appear to view timeliness and attendance issues as priorities to be resolved (i.e., in an integrated fashion with assistance from psychology staff, when appropriate). However, as noted elsewhere, with the revised monthly review policy, teams were required to review attendance issues should certain criteria be met. Similarly, lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. The Facility remained out of compliance with this provision.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	Based on the review of the sample of ISPs: ▪ Although some improvements were seen with regard to teams' use of data, none of the 10 ISPs reviewed appeared to be driven by a review of objective data for each of the related action plans, and the presence or lack of progress on measurable objectives and outcomes. Problems included: ▪ In reviewing ISPs or observing ISP meetings, often the action steps in the IHCPs identified the frequency of data collection, but not how frequently the person responsible for reviewing progress and efficacy would review the data. ▪ Frequently, the data to be collected was not defined. As just a couple of examples: o For Individual #159, data to be collected often was missing (e.g., behavioral data, psychiatric data, collection of weight data, percentage of meals eaten, nursing assessment data, etc.). ▪ In addition, this varied, but problems were seen with regard to the definition of who would collect the data. For example, the following provides just one example of a goal for which no one was identified as responsible for regularly assessing the individual in order to collect the necessary data: "[Individual #77] will maintain clear patent airway aeb [as evidenced by] no Reflux episodes, have normal breath sounds, absence of coughing and O2 [oxygen] saturations of >95% RA [Room Air] during the next 12 months." ▪ This varied, but generally, in the IHCPs reviewed, in the column for "Persons Responsible for Reviewing Progress and Effectiveness & Frequency of Review,"	Noncompliance

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		the Persons Responsible were identified, but not the "Frequency of Review." As just a couple of examples, for Individual #310, he was to maintain a fair or better oral hygiene rating for the year, but it was not clear how often this would be assessed. He was only to see the dentist to monitor for oral health annually. This was not sufficient to provide the team with feedback regarding whether or not their plan was working, or needed to be revised. Similarly, no behavioral objectives were included in Individual #310's IHCP for the BSP. As a result, it was unclear how the IDT would monitor his pica behavior. The overarching concern was that many goals and objectives were not specified in individuals' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., goals/objectives related to therapy plans, BSPs, psychiatric treatment plans, restraint reduction plans, reduction of restrictive practices, etc.). As a result, appropriate data was not identified to assist teams in decision-making, and existing plans were not effectively incorporated into the overall ISP planning and implementation process. Although teams discussed data in the context of the IRRF, the data available on the IRRFs varied in quality and comprehensiveness. This is discussed in further detail with regard to Section I. Of ongoing concern was the lack of data presented in the ISP and/or IRRF in relation to SAPs, behavioral health plans (i.e., PBSPs, psychiatric treatment plans, and counseling plans), as well as direct therapy plans. As is discussed below with regard to Sections K and S of the Settlement Agreement processes were not yet fully implemented to determine the reliability of the data, but efforts were being made in this regard. However, there continued to be some indications that the data being collected was not reliable. Since the last review, improvement continued to be seen with regard to data being used to inform some of the at-risk discussions. However, data that should have been included, but was not, related to skill acquisition plan data, data related to the implementation of other plans (e.g., PNMPs, PBSPs, psychiatric treatment plans, etc.), and details regarding individuals' successes or failures, etc. In addition, some improvement was seen with some teams in terms of defining the data to be collected, frequency of data collection and review, and persons responsible. However, much work was still needed in this regard. The Facility remained in noncompliance with this requirement.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated	As noted in the previous reports, and based on the current review of ISPs, this was an area that required continued improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and habilitation therapies; nursing and medical; and between the disciplines responsible for the	Noncompliance

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	outcomes, services, supports, and treatments are coordinated in the ISP.	provision of physical and nutritional supports to individuals served. As noted above with regard to Section F.1.a, some improvements were being seen with the interdisciplinary discussions that occurred during ISP meetings. However, more work was needed to ensure adequate collaboration and coordination between team members.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	DADS Policy #004.2 at I.C.22 required the ISP to be accessible and comprehensible to staff who must implement it. At the time of the review, the ISP was located on the residential unit, but locked in a cabinet for security reasons. Given privacy and security requirements, this was appropriate. It appeared that if staff needed access to the locked records, a key was easily available. Copies of the ISPs as well as the skill acquisition programs also were accessible to staff in Individual Notebooks. The Lead QIDPs were responsible for checking a sample of Individual Notebooks each week to ensure the ISPs were present and up-to-date. Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding. However, as more IHCPs are developed, it will be important to ensure that clinical terminology is included, but defined as appropriate. Another issue related to comprehensibility of the 10 ISPs reviewed was the lack of delineation of responsibility for the implementation of the plan. Although as noted above, the role of direct support professionals was becoming better defined, this in large part was due to the fact that the ISPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document. Although it will be necessary for the separate plans to continue to exist (e.g., PBSPs, PNMPs, health care plans, etc.), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall ISP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members. In addition, without clear methodologies, it will continue to be difficult for direct support professionals to consistently implement programs and supports (e.g., "encourage" and other similar terms would be difficult to implement). In addition, training responsibilities had been delineated for the various components of the ISPs. For example, QIDPs were responsible for training direct support professionals on the ISP action plans, with a focus on what their specific responsibilities were. The RN Case Manager would be responsible for training on the Direct Support Professional Instructions. Education and Training staff provided training on the skill acquisition	Noncompliance

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		programs, and the various disciplines were responsible for training on plans such as PNMPs and BSPs. Tracking systems were in place for some, but not all of these training requirements. The Facility remained out of compliance with this provision. Additional work was needed to ensure various staff's responsibilities were clearly delineated in easily understood terminology, and training was completed on the various components of the ISPs.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	DADS Policy #004.2 at III.A addressed ISP monthly reviews. This included the requirements of the Settlement Agreement for monthly reviews and action, as appropriate. It required that within 10 calendar days after the end of the review period, the monthly reports would be filed in the individual's record. Since the last review, the CCSSLC Policy F.10 – ISP Monitoring/Monthly Review Process had been revised with an implementation date of 2/6/14. This revised policy shifted the focus to integrated monthly reviews, and included roles for team members other than the QIDPs, including, the RN Case Managers, Residential Coordinators, and the Behavioral Health Specialists. Additions or expansions were made with regard to restrictive practices, change of status, ISPAs, Infirmary admissions/hospitalizations, medication changes, medical/dental appointments and refusals, desensitization, peer-to-peer review, restraints, level of supervision, behavioral health, injury trending, unusual incidents/abuse and neglect, PNMPs, assessments and evaluations, and class or work refusals. As noted in the Monitoring Team's last report, parameters were set for when the teams needed to take action related to attendance issues, and the types of actions teams needed to take depending on the cause of the attendance issues. Although this format did not yet cover all of the aspects of the ISP and IHCPs, as the Settlement Agreement requires, it was a significant improvement over the previous format, and included some important components that helped to provide a more rounded picture of the individual on a monthly basis. In addition, the revisions included a cumulative record of the individual's status throughout the ISP year. In other words, for each of the entries, the previous months' information was included. Based on a review of a sample of monthly reviews that had been completed using the new format, it was easier to quickly see when progress had occurred or was lacking. This should assist teams in determining when action is needed. In addition, as discussed in the Monitoring Team's previous report, in May 2013, the Programming Review Committee began meeting. The group met weekly and reviewed three individuals' ISPs and monthly reviews. The individuals selected had had ISP meetings three months prior, allowing time for the QIDP to complete the ISP document	Noncompliance

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		and at least one monthly review. Leadership from the QIDP and Education and Training participated in the meetings, as well as the QIDPs and the staff responsible for the development of skill acquisition programs. The documents were provided ahead of time, and team members were expected to complete a monthly review assessment tool and come to the meeting with comments prepared. As noted in the last report, this offered a respectful peer review opportunity for the monthly reviews and ISPs. Based on this review, it appeared that it was having a positive impact on the quality of the monthly reviews. It was anticipated that next steps would be establishing inter-rater reliability with the audit tool the Committee used that had been modified to reflect the new integrated monthly review format, aggregating and analyzing data collected from this process, and identifying and acting on any problematic trends. Based on a review of the sample of ISPs: ▪ Based on the sample of 10 records, three (30%) had timely monthly reviews each month for the previous three months. Those that did included Individual #141, Individual #297, and Individual #310. ▪ For none of the monthly reviews completed (0%), the responsible interdisciplinary team member(s) for each program or support included in the ISP assessed the progress and efficacy of the related interventions. However, as noted above, since the last review, the most recent monthly reviews evidenced more involvement from the RN Case Managers Residential Coordinators, and Behavioral Health Specialists. This was a positive development. In order to avoid duplicative work, consideration should be given to combining other monthly reviews (e.g., for Behavioral Health Services), and/or assessments (e.g., the Education and Training annual assessment) with the monthly review process. ▪ For eight individuals (i.e., Individual #285, Individual #141, Individual #297, Individual #296, Individual #298, Individual #359, Individual #146, and Individual #77), a lack of expected progress or change in recommended supports was noted requiring action. In two of these instances (25%) (i.e., Individual #297 and Individual #359), adequate action was documented (i.e., the QIDP identified the need for the team to meet to discuss lack of progress. Lack of action or inadequate action were noted for the remaining individuals [i.e., Individual #285 and Individual #141, for whom it was unclear what, if any, action was taken; Individual #296, for whom, in some instances, notes appeared to indicate that the team had taken action, but in others, it was not clear what the team had done or would do (e.g., electric toothbrush not purchased for two months in a row, or no visits to group homes conducted; although the QIDP indicated that follow-up would occur in relation to Individual #298's refusal to participate in SAPs, this same follow-up need was listed in two consecutive monthly reviews, so it was unclear if it was done, and if so, what the results	

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		were; Individual #146 was not making progress on some SAPs due to refusals, but it was not clear that the team reconsidered what should be done; and for Individual #77, it appeared for some SAPs, the team should have reviewed lack of progress or regression, but there was no indication this was done]. In addition, as noted above, the reviews conducted did not comprehensively address all action plans included in individuals' ISPs. Therefore, it remained unclear if problems existed that should have been addressed. Examples are provided in various sections of this report of individuals experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to medical and nursing care, as well as physical and nutritional management supports. Although clearly more work needed to be done, it was positive that the new monthly format drew attention to this issue by including sections on changes of status, as well as Infirmary Admissions and hospitalizations. Improvements in the measurability of goals and actions steps related to the identification of individuals' changes in status and then monthly (and more frequently as necessary) review of this data will be necessary for teams to identify changes of status early and respond accordingly. Since the last review, the Facility had taken a number of positive steps forward in developing a more integrated monthly review format. The addition of sections of the monthly report devoted to areas that Behavioral Health Specialists Residential Coordinators, and RN Case Managers were responsible for monitoring were good additions to the monthly review format. In addition, the change to a cumulative report that helped to show progress or lack thereof over time was a positive one. However, the Facility remained out of compliance with this provision. In addition to needing to add more components to the monthly reviews to ensure each program and support was reviewed, teams needed to take action when results of the reviews indicated a lack of progress, or identified other issues that required intervention, such as changes in status.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with	Previous reports have described training CCSSLC staff underwent with regard to the ISP process. Updates included: ▪ As noted in the Monitoring Team's last couple of reports, the QIDP Coordinator, the Director of Education and Training, two Program Coordinators, and a Program Compliance Monitor worked together to develop a draft I-Learn course entitled: "Individual Support Plan Cycle." Since the last review, it had been developed as an I-Learn course, and was made available to Facility staff. Based on information the Facility provided, all IDT members had completed the course, except for direct support professionals. As indicated in previous reports, this training provided some valuable information related to the ISP cycle, and the roles of various team members. Work was underway to develop a version that	Noncompliance

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	their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	would be more relevant to direct support professionals. ▪ In December 2013, the QIDP Coordinator provided refresher training to all QIDPs on the PSI and ISP processes. ▪ The Supporting Visions: Person-Centered Planning curriculum continued to be used as part of New Employee Orientation (NEO). ▪ As noted in the last report, in August 2013, all IDTs participated in training on the At-Risk process that CCSSLC had developed. This training is discussed above, as well as with regard to Section I. It incorporated information about the general ISP process, as well as in-depth information about the IRRF and IHCPs. As noted above, it provided a good structure for teams to use when developing action plans. ▪ The QIDP Coordinator had developed a Job-Specific Training Schedule, and the QIDP Educator continued to implement it with new QIDPs. It identified the QIDP responsibilities, as well as essential job functions, and set forth a structure for documenting that new QIDPs completed training on each of the listed items. Although it was not competency-based, the list of responsibilities and functions appeared thorough. It was positive that a more formal process for ensuring QIDPs were familiar with their many duties had been developed and was being implemented for new QIDPs. ▪ The Q Construction: Facilitating for Success training was still provided to new QIDPs. This training included a written test that each participant completed at the end of the classroom training. It also included a competency checklist. As indicated in previous reports, as the checklist is implemented, changes likely will need to be made to further define certain competencies, and to ensure reliability across reviewers. ▪ The QIDP Coordinator also continued to provide training to QIDPs as CCSSLC policies or procedures changed. ▪ As noted in the last report, in June 2013, the QIDP Coordinator provided training to IDTs on each of the Units. Scenarios were used to prompt discussion from the teams about writing ISPAs, including related action plans. This was an innovative approach to try to expand teams' skills in this area. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As indicated in previous reports, QIDPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate ISP document. Such competency measures should be clearly defined and include criteria for achieving competence. The Facility continued to use Q Construction: Facilitating for Success to measure competence in facilitation. In addition, the monitoring checklist included some indicators that could be used to assess QIDPs' facilitation skills as well as their skills in finalizing the ISP document, but	

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		specific criteria had not yet been determined. At the time of the last review, the QIDP Educator and one QIDP had been deemed competent. Since then, two QIDPs had been deemed competent. One of these QIDPs had since left the Department. A total of 11 QIDPs and two Lead QIDPs still needed to achieve competence on facilitation. None of the QIDPs had yet been deemed competent with regard to finalizing the ISP document. ▪ Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. ▪ As Facility staff recognized, even though some training on the development of action plans had been provided, more likely was needed. ▪ This section of the Settlement Agreement also requires: "Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised." Based on interview, this was an area still under development. As noted in relation to Section F.2.f, training responsibilities had been delineated for the various components of the ISPs, and some training was occurring. However, work was still needed to ensure all staff had achieved competence on the implementation of specific ISPs. Progress was being made on training staff, but the Facility remained out of compliance with this provision. In addition to focusing efforts to provide additional training and technical assistance to improve the team process during team meetings, QIDPs' competence with meeting facilitation as well as the development of the ISP documents should be assessed, and the Facility should ensure that staff responsible for the implementation of the plans successfully complete competency-based training.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on data the Facility provided, between 8/1/13 and 1/31/14, three individuals had been admitted to the Facility. All three individuals' 30-day ISP meetings (100%) had been held within 30 days of their admission. With regard to the timely completion of ISP documents, on 11/8/13, the QIDP Coordinator instructed QIDPs to finalize ISP draft documents within 15 days of the ISP meeting. Based on interview with the QIDP Coordinator, this improved timeliness, but the quality of the documents produced was of concern. At the time of the review, this was an area in which the Facility was still working. The QIDP Coordinator submitted data monthly to the QA/QI Council. Data showed that in August 2013, timely submission	Noncompliance

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		occurred at a rate of 35%, while in January 2014, the rate was 53%, with a generally improving trend, but a low of 24% in December 2013. Facility staff recognized that for the ISP to be "put into effect" within 30 days, the ISP needed to be completed and filed, but actions also were needed to ensure it was being implemented. The Facility had begun to take some steps to ensure staff were trained on individuals' ISPs. Specifically, in-service training was required for a number of components of the ISP, and various staff were responsible to complete this training. For example, the RN Case Managers were responsible to train direct support professionals on the "DSP [Direct Support Professional] Instructions," Active Treatment staff were responsible for providing training on the Skill Acquisition Programs, Behavioral Health Services Providers trained on the PBSPs, PNMP Coordinators trained any portions of the PNMPs that were not included in the standard training, and QIDPs provided training on other ISP action plans. The Facility submitted sign-in sheets for training completed for the individuals in the sample. This showed that some training was occurring, but the Facility indicated there currently was no tracking system to easily identify the percentage of staff that had completed each required training session, and the staff who still needed to complete the training. The Facility remained out of compliance with this provision.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Progress had been made and sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that ISPs are developed consistent with this section of the Settlement Agreement. Positive aspects of the process included: ▪ DADS Policy #004.2 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. ▪ As noted in the previous reports, the Facility had revised its policy on Quality Assurance for Section F. Policy F.13, revised draft dated 3/7/13, provided some additional detail about the roles and responsibilities of the staff at CCSSLC with regard to monitoring ISP meetings and documents. ▪ CCSSLC had continued to revise its monitoring/audit tools for Section F. Since the last review, the QIDP Coordinator and Director of Education and Training had worked together, along with input from the QA Program Compliance Monitor, to develop and revise the Section F and Section S Monitoring Tool. Given the overlap in and interrelatedness of the requirements in these sections, it made sense to combine monitoring efforts. In December 2013, the most recent version of this tool began implementation. ▪ The QIDP Coordinator and Director of Education and Training also had	Noncompliance

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		developed other mechanisms to review processes and products related to ISP development and implementation. Each of these involved the use of audit tools. Specifically, the Assessment Review Committee looked at specific aspects of the quality of assessments, and the Programming Review Committee reviewed the quality of monthly reviews as well as SAPs, as discussed in further detail with regard to Section F.2.d. ▪ A Program Compliance Monitor from the QA Department, as well as the QIDP Coordinator and Director of Education and Training were conducting the reviews. At the time of the review, this had been reduced from four audits a month to two, due to the new monitoring format. ▪ As noted in other subsections of this report, the Facility also had mechanisms in place to collect other relevant data, such as the timeliness of the submission of assessments, and attendance at ISP meetings. The QA/QI Council was reviewing this information regularly. ▪ As noted previously, the Facility had implemented a Corrective Action Plan for Section F. It related to the need to improve monthly reviews, and resulted in the development and implementation of the Programming Review Committee. The Committee appeared to be providing a good peer review system for certain components of ISPs and monthly reviews. Similarly, the Assessment Review Committee offered a peer-review forum for specific components of assessments, such as the incorporation of preferences and strengths, identification of individuals' needs, development of meaningful goals, and recommendations related to transition to the most integrated setting. Both of these committees used audit tools, and next steps were establishing inter-rater reliability, and using the data collected on a more systemic level. Areas in which improvements should continue to be made in order to achieve compliance, included: ▪ Based on discussion with the QIDP Coordinator, different audits were completed for the Self-Assessment for Section F and for the internal quality improvement function. It appeared that this was due to the need to complete the indicators that State Office required for Section F for the Self-Assessment, and the Facility's recognition that different indicators would be more helpful. It is not a good use of staff's time to conduct separate audits for these two purposes. The self-assessment function is one that should outlive the Settlement Agreement, and should be functional for the Facility. The Facility should work with State Office to develop an audit process the results of which can be used for both the Self-Assessment and internal quality improvement processes. ▪ For the new Sections F and S audit tool, inter-rater reliability needed to be established with the QA and programmatic staff (i.e., QIDP Coordinator and	

#	Provision	Assessment of Status	Compliance
		Director of Education and Training) responsible for conducting audits. Facility staff were actively working on this piece. As noted in previous reports, the staff had been holding consensus meetings to discuss monitoring results. The continued refinement of instructions/guidelines, including methodologies as well as standards, will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). ▪ Although the Facility was able to produce aggregate data for the indicators on the Sections F and S monitoring tool, the ISP audit tool, the Monthly Review audit tool, and the Section F monitoring tool, documentation submitted indicated: "At this time, Section F does not develop reports based on the findings from each of the tools. This will be a priority for the Section F Lead during the next 6 months." ▪ Although the QIDP Coordinator regularly presented at the QA/QI Council on Section F, analysis of the data from the various monitoring tools was not regularly presented and was a needed addition. Other data from Section F was being presented, such as data related to timeliness of assessments and attendance of IDT members at annual ISP meetings. As a result, a number of important areas of need had been identified, as well as some potential solutions. Review of additional data and development and implementation of concrete plans to address the outstanding areas were areas that required attention. Section F requires the involvement of all disciplines, and this would be an area where a systemic CAP might be useful to tackle some of the more difficult issues, such as the quality of assessments, integration of supports and services, development of quality actions plans, etc. It was positive that the Facility was continuing to work on developing meaningful audit tools with guidelines, and that the QIDP, Education and Training, and QA Departments were meeting regularly to review results. However, more work was needed to ensure reliability of the data, and fully utilize the data for quality assurance purposes. The Facility remained out of compliance with this provision.	

SECTION G: Integrated Clinical Services	
Each Facility shall provide Integrated Clinical Services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section G; o For morning medical meeting minutes, copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed for following dates: 3/24/14 - 3/28/14; o For hospitalizations for the specific 30-day period (15 days prior to the Monitoring Team visit to 45 days prior to the Monitoring Team visit), copies of follow-up Individual Support Plan Addendums (ISPA): Individual # 366, Individual #191, Individual #252 (3/4/14), Individual #130, Individual #99, Individual #252 (3/6/14), and Individual #239; o For concerns identified needing closure at morning medical meetings for period of 15 - 45 days prior to the Monitoring Team's visit, documents providing evidence of closure (i.e., minutes of medical staff meeting, copy of ISPA addressing concern, etc.); and o From each PCP's caseload, two individuals with copies of all consultant reports (medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all Integrated Progress Notes (IPN) commenting on consultant reports (medicine and surgery inclusive of subspecialties) (agreeing or reason not agreeing) and any ISPA related to the consultant report: Individual #151, Individual #338, Individual #329, Individual #186, Individual #325, Individual #187, Individual #332, and Individual #235. ▪ **Interviews with**: o Ingela Danielsson-Sanden, MD, Medical Director; and o Laura Ramon, RN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: consultation audit tool. o These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations, because focus was only on Section G.2. Also, there was no sampling of consultations for which an ISPA would be indicated. The audit tool for consultation was extensive, but the eligible population needed a focus on consult recommendations requiring Interdisciplinary Team involvement. o The one monitoring tool included adequate methodology involving record reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). This sample size was adequate

	to consider it a representative sample as far as numbers. As mentioned, focus on those consult reports that required IDT collaboration was needed. o The following staff/positions were responsible for completing the audit tools: Medical Program Compliance Nurse. o Adequate inter-rater reliability had not been established between the Medical Program Compliance Nurse and the QA nurse. This aspect appeared to be in the planning stage. ▪ The Facility did use other relevant data sources that showed whether or not the intended outcomes of the Settlement Agreement were being reached. There was information for tracking the activities of the Integrated Clinical Services Team meeting, such as items needing closure, follow-up to closure of post-hospital ISPAs, consult reports, and open record reviews. There was no analysis of information available, although it appeared the tracking database was newly implemented for only the most recent month(s). The quality of the data maintained in the databases was noted to be complete and accurate for data that was derived from the Medical Department. The QA data for attendance at ISP meetings appeared to need further analysis. Examples of databases/data sources that were not considered included tracking the number of recommendations from the open record reviews, the number of new preventive steps or new triggers identified in post-hospital ISPAs, any system improvements that derived from a concern that needed subsequent closure, the quality of the content of the IRRF for all applicable disciplines, and the quality of the IHCP, which other departments have primary responsibility for development with input from the Medical Department. ▪ The Facility presented data in a meaningful/useful way, but some concerns were noted. Specifically, the Facility's Self-Assessment for Section G presented information in table format. The consult audit tool was composed of numerous clinical indicators, and the information was clear. The Facility: o Presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. The audit tool for consultation processing by PCPs did capture the quality of the consultation process. There was no measure of the quality of the ISPA (i.e., timeliness, content, reference to preventive steps, etc.). ▪ The Facility rated itself as being in non-compliance with Section G.1 and did not rate Section G.2. This was consistent with the Monitoring Team's findings for Section G.1. ▪ The Facility data did not identify areas in need of improvement. For those areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying for example, the impact of the post-hospital ISPA findings for new triggers or preventive steps to be taken. There was also a significant role for other clinical disciplines in Section G.1 to provide evidence of Integrated Clinical Services, but the Medical Department appeared to be the only department responding to this section.

	Summary of Monitor's Assessment: The Integrated Clinical Services Team meetings were one forum that demonstrated inter-departmental critical discussion and collaboration in responding to acute changes in status, such as hospitalizations and Emergency Room (ER) visits. The meeting was well attended by numerous departments, and there were opportunities for several departments to provide periodic updates in addition to the daily discussion of those acute health and behavioral changes of status. Improvement was needed with regard to follow-through and timely response for post-hospital Individual Support Plan Addenda, as well as the content of those ISPAs in addressing health concerns. For example, from August 2013 through January 2014, there were 42 ISPAs completed for individuals that had been hospitalized or admitted to the Infirmary. The average length of time varied per month from eight days to 31 days. Average time to completion from August 2013 through January 2014 was 17 days. Considerable support needs to be provided by Facility Administration to ensure timely completion of these ISPA. The delay in ISPA development and implementation potentially could affect the health and safety of the individuals, especially those recently hospitalized. One or more of the open record reviews were of high quality and provided additional perspective and opportunities to address individuals' health needs. The Facility used an extensive audit tool to review consultation reports, including the Primary Care Providers' interpretation of the consult reports. There were no examples provided of consults that needed timely IDT response through the creation and implementation of new ISPAs. A tracking mechanism to focus on those specific consults is needed. For the many clinical indicators that the Facility measured, the Facility's data showed good results, but additional focus was needed on measuring the IDT response, where necessary. The Medical Department had already identified this need, and interdepartmental communication had begun. Another important forum in which integrated clinical services were necessary was the ISP process. There needed to be further training of Qualified Intellectual Disabilities Professionals (QIDPs) and teams in determining which departments were essential to attend each ISP meeting. The Medical Department appeared to have made great strides with regard to Sections G.1 and G.2. Other departments needed to reflect similar progress and momentum in order for the Facility to be in substantial compliance with Section G.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide Integrated Clinical	The Facility provided the attendance per department at the ICST meetings for the time period 3/17/14 through 3/28/14, which included 10 working days. The following is derived from this information:	Noncompliance

#	Provision	Assessment of Status	Compliance

Services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.

Department	# Days Attended	Department	# Days Attended
Nursing Administration	6	Infirmary	9
Hospital Liaison	8	Infection Control	8
Habilitation Therapies	7	Physical and Nutritional Management Team	7
QIDP	5	Residential	8
Dietary	0	Quality Assurance/Quality Improvement	7
Chaplain	0	Pharmacy	9
Psychology	2	Psychiatry	9
Dental	9	Medical	10
Incident Management	0	RN Case Manager	9
Medical Compliance RN	9		

The following information summarizes the contents of the morning medical meeting minutes for the week of 3/24/14 through 3/28/14, the week prior to the Monitoring Team visit:

- The number of meeting minutes totaled four of five meetings.
- Zero of five (0%) meetings included a record of attendance. It was reported by the Medical Department that five of five meetings had an attendance roster completed.
- Five of five (100%) meetings included discussion of the Medical 24-hour Log, as indicated by handouts and/or meeting minutes.
- For three of five (60%) meetings, there was documentation of the on-call provider report or there was no report indicated (i.e., the on-call provider did not receive any calls). For one meeting, no minutes were submitted, and the handouts did not provide further information. For one meeting, the minutes did not include an on-call provider report or a reason for not including this section in the minutes.
- Five of five (100%) minutes included a report by the Hospital Liaison Nurse.
- The campus 24-hour log was reviewed in four of four (100%) applicable meeting minutes and was included as a handout for five of five meetings.
- For three of five meetings, there was an appointment/assignment of a member of the morning meeting to review the open record for seven or more days prior to the hospitalization/ER visit.
- The minutes and handouts provided to the Monitoring Team member indicated there were four Infirmary admissions during the week. The Infirmary census ranged from five to seven daily. A parallel review by the Medical Department

#	Provision	Assessment of Status	Compliance
		indicated there were two Infirmary admissions. ▪ The hospital census was discussed at five of five (100%) meetings. There were three hospitalized individuals on each of the days reviewed. ▪ Two of five meetings included an open record review for three assigned cases. ▪ From the information submitted to the Monitoring Team member, no concern needing closure was assigned during the five meetings. The Medical Department identified one concern that had been assigned during this time period. ▪ Two meetings included closure of four assigned items/concerns. ▪ No chemical restraints were reviewed during the five meetings. ▪ No ISPAs were discussed during the five meetings. ▪ One meeting included a PNMT report. ▪ One meeting included information provided by the Dental Department. ▪ One meeting included an update by the Infection Control Nurse. ▪ One meeting included a skin integrity report. ▪ No meeting included a report of any individuals with significant weight gain or loss. The Facility submitted ISPAs generated for hospitalizations that occurred during the 30-day time period of 15 through 45 days prior to the Monitoring Team's visit. This time period was selected to allow completion of ISPAs for hospitalizations. There were ISPAs for seven hospitalizations of six individuals. These were reviewed to determine the reason for hospitalization, evidence of a record review for events prior to the hospitalization, evidence of identification of new triggers as early signs and symptoms of illness, evidence of recommendations to increase monitoring of specific parameters, and additional steps implemented to reduce the risk of recurrence of illness and hospitalization. ▪ Of the six individuals, zero individuals were hospitalized for concerns that did not apply to these measures and were excluded (i.e., planned surgery, etc.). ▪ For an individual with more than one hospitalization, measurements did not separate out the various admissions per individual, but all documentation related to the hospitalizations was used to monitor the quality of the team approach to resolving health care issues to address the cause of the hospitalization or repeat hospitalization. ▪ Based on the clinical needs of the individual, not all individuals needed additional action steps/processes as part of the IDT review. However, the IDT did demonstrate one or more processes in a number of cases. The findings included the following: o Reference to a record review/open record review was documented in zero of seven post-hospital ISPAs. o The IDT identified new triggers or early signs/symptoms in one of six individuals. o The IDT identified the need for increased monitoring in one or more aspects of care in three of six individuals. o The IDT identified the need for additional consultations in three of six	

#	Provision	Assessment of Status	Compliance
		individuals. o The IDT identified the need for additional treatment in one of six individuals. o The IDT identified other preventive measures in three of six individuals. o For four of six ISPAs (67%), the IDT appeared to have conducted an appropriate review and identified the next steps needed, if applicable. o For two ISPA, steps to prevent a repeat hospitalization were not addressed. ▪ The time from the start of hospitalization or discharge from the hospitalization to the creation of the initial ISPA was within five days in four of five (80%) ISPA submitted. For one individual, with frequent and prolonged hospitalizations, timing was not measured. For that one individual, the IDT did meet at periodic intervals to provide updates and determine steps to be taken in anticipation of discharge from the hospital. A document entitled "CAP Tracking" indicated that a schedule was developed for representation of QIDPs, Behavioral Health, and Residential Departments to attend the Integrated Clinical Services meeting The Medical Department submitted documentation of closure to morning medical meetings for the time period 30 to 60 days prior to the Monitoring Team's visit. This time period was selected to allow follow-up closure to concerns documented at the morning medical meeting. Twenty-seven closure concerns were submitted that were tracked. Fourteen of 27 had been closed and evidence of closure was provided for these 14. Three of 27 were listed as closed, but information was not provided as evidence of closure. Three of 27 had appointments at future dates. Seven had no information concerning closure and continued to be tracked. Data was provided concerning completion of open record reviews and ISPAs for individuals hospitalized or admitted to the Infirmary. From August 2013 through January 2014, there were 38 open record reviews. Average time to completion varied per month, from four days to 10 days. Average time to completion from August 2013 through January 2014 was 5.3 days. During this same time period, there were 42 ISPAs completed. The average length of time varied per month from eight days to 31 days. Average time to completion from August 2013 through January 2014 was 17 days. Considerable support needs to be provided by Facility Administration to ensure timely completion of these ISPA. The delay in ISPA development and implementation potentially could affect the health and safety of the individuals, especially those recently hospitalized. Attendance at ISPs was one measurement of integrated clinical services. Information was derived from the Quality Assurance Department, and was not confirmed by separately submitted evidence (although, this data was different from that provided in the Facility's Self-Assessment for Section G, calling into question the validity of the data). However, the	

#	Provision	Assessment of Status	Compliance
		following provides information for several clinical departments per month (i.e., the number of required ISPs attended by each department, and the number of ISPs per month for which attendance was required for each department, followed by percentage attendance rate for required ISPs each month:	

Department	December # of ISPs Required to Attend	December % of Required ISPs Attended	January # of ISPs Required to Attend	January % of Required ISPs Attended	February # of ISPs Required to Attend	February % of Required ISPs Attended
Medical	14	7 (50%)	19	11 (58%)	19	17 (89%)
Dental	2	0 (0%)	6	1 (17%)	9	5 (56%)
Pharmacy	1	0 (0%)	2	0 (0%)	0	0 (0%)
Psychiatry	7	4 (57%)	5	5 (100%)	5	4 (80%)
Nursing	16	16 (100%)	19	19 (100%)	19	19 (100%)
OT	6	3 (50%)	5	4 (80%)	5	4 (80%)
PT	4	4 (100%)	6	6 (100%)	8	8 (100%)
Speech	7	4 (57%)	1	1 (100%)	2	1 (50%)
Psychology	10	8 (80%)	5	3 (60%)	10	8 (80%)
Dietary	2	0 (0%)	3	0 (0%)	2	1 (50%)

The accuracy of the data was reviewed for the Dental Department. There were several concerns about the accuracy of the data, because some of the individuals had good or fair oral hygiene scores and the rationale requiring Dental Department attendance at the ISP was not clarified (e.g., the individual required pre-treatment sedation or the use of general anesthesia, or was involved in a desensitization program). One of the challenges facing the Dental Department was having ISP meetings requiring dental staff attendance on the same day when Total Intravenous Anesthesia (TIVA) procedures were scheduled. It is recommended that the QIDP, QA Department, and Dental Departments review the list of indications for Dental Department attendance at ISP meetings, and provide alternative

#	Provision	Assessment of Status	Compliance
		options for communication (when there is a scheduling conflict such as TIVA appointments) to the IDT should there be an individual for whom a dental department representative's attendance is required. There had been considerable email communication amongst departments, but no systems approach to resolving this concern. Using the criteria State Office has provided regarding attendance at ISP meetings, QIDPs and other team members should be trained/retrained. The QA Department working in conjunction with the QIDP Department should create a monitoring system to ensure accuracy of this information. The Facility remained in noncompliance with this provision. However, CCSSLC had made some progress, particularly with regard to the integrated discussions occurring at the ICST meetings, and the development and initial implementation of an ISPA process for individuals with acute changes in health status.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The Facility submitted consultant reports for two individuals from each PCP caseload, as well as any Integrated Progress Notes (IPNs) commenting on the consultant reports. Thirty-five consultations were submitted for review, with a range of three to seven consultations per individual. These are listed above in the documents reviewed section. Review of these documents revealed the following, based on the submitted documentation: ▪ Of the 35 reviewed, 35 (100%) included the PCP initials, indicating review by the PCP. ▪ Of the 35 reviewed, 35 (100%) included the date on which the PCP conducted the review. ▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs and ISPAs were requested. When submitted, these were reviewed. o Of the 35 reviewed, 30 (86%) consult reports included documentation of agreement or not with the consultant recommendations. o Of these 35, 28 (80%) included PCP IPN entries. ▪ Of these, there was evidence that the IDT was informed of the consultation results in 16 of 35 consults. A "Consultant Recommendation Review" form was utilized for the IDT members to sign off that the consult was reviewed. It also indicated whether an ISPA was indicated. ▪ Of these, zero ISPAs were indicated as follow-up by the IDT to the consultant report. The Medical Department provided data generated from one or more audits of the consultation process. Data was available from August through October 2013. Twenty-seven of 390 consults were reviewed to determine whether the consultation was reviewed, and signed and dated by the PCP. Based on the Facility's data, compliance for the sample audited	Noncompliance

#	Provision	Assessment of Status	Compliance
		was 100 percent. PCPs were 78 percent compliant with completing an IPN documenting agreement or not with the consultant recommendations. There was 97 percent compliance with writing follow-up orders to consultant recommendations. In 60 percent of the 27 consults reviewed, the IDT was informed as to whether or not the PCP agreed with the consultant recommendations. Documentation indicated that IDT members reviewed approximately 50 percent of the consult reports. None of the sample chosen were for consults that led to ISPA creation. A separate audit tool was implemented for Section G.2, as of 11/1/13. Data was available for 26 consults from a total of 249. The time period for the submitted data was November 2013 through January 2014. According to the Facility's data, when referring an individual to a consultant, the referral form included the rationale for the consultation in 97 percent of the consults. All consult requests reportedly included important aspects of the clinical history. The Facility's data showed that supporting documentation (i.e., labs, x-rays, etc.) was included in 100 percent of the referrals. Supporting documentation included current medications in 100 percent of the referrals. The Facility's audit showed there was 100 percent compliance by PCPs in reviewing, signing, and dating the consult reports within five working days. There was 97 percent compliance in documenting agreement or not with the consultant. However, the sample did not include any consult recommendations that required an ISPA or IDT meeting. The Facility's data indicated that when writing an IPN addressing the consult, PCPs were 83 percent compliant with identifying the specialty and the date of the consultation. An IPN reflected the rationale for referral to the specialist in 84 percent of the consults. According to the Facility's data, the IPN included a statement as to whether or not the PCP agreed or not with the consultant recommendations in 89 percent of the sample. Important aspects of the consult report/findings were included in 93 percent of the IPN. The Facility concluded that for the 26 consultations, all recommendations were followed. To assist the IDT in determining when ISPAs needed to be developed for consultant recommendations, guidelines were developed (as discussed with regard to Section L.4). However, this document appeared to remain in draft form. As evidence of completion of the process for closure of consultant recommendation, it will be important for the Facility to sample consultations that result in ISPA creation by the IDT that addresses specific consultant recommendations. In addition, it is important for PCPs to enter IPN entries with regard to consultations. The Facility remained in noncompliance with this provision.	

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section H; and o For two most recently completed annual medical evaluations/assessments of individuals from each PCP's caseload, copy of the active problem list, with identification of four significant diagnoses, with list of criteria/evidence justifying each of these four diagnoses: Individual # 343, Individual #225, Individual #31, Individual #151, Individual #106, Individual #294, Individual #229, and Individual #342. ▪ **Interviews with**: o Ingela Danielsson-Sanden, MD, Medical Director; and o Laura Ramon, RN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section H, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: audit tools for various diagnoses, such as seizures, osteoporosis, constipation, hypertension, diabetes mellitus, and Down syndrome; quality of care and documentation review of Emergency Room visits and hospitalizations; as well accuracy of significant diagnoses listed in the active records. o These monitoring/audit tools included some indicators to allow the Facility to determine compliance with the Settlement Agreement. However, further development of clinical audit tools is needed to expand review of the most common clinical concerns. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews, and review of databases providing details of ER visits and hospitalizations. o The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample size(s) were adequate to consider them representative samples. o The adequacy of the monitoring/audit tool instructions/guidelines to ensure consistency in monitoring and the validity of the results was not reviewed. o The following staff/positions were responsible for completing the audit tools: Medical Program Compliance Nurse. o Adequate inter-rater reliability had not been established between the Medical Program Compliance Nurse and the QA nurse. ▪ The Facility did use some other relevant data sources to show whether or not the intended

	outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be complete and accurate. Examples of databases/data sources that were not considered included evaluation of treatments being provided, the response of the PCPs to abnormal test results, etc. (i.e., areas important to Section H.6). ▪ The Facility consistently presented data in a meaningful/useful way, but some problems were noted. Specifically, the Facility's Self-Assessment: o Included numerous charts with brief analysis/interpretation of findings based on the data. o Presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o There was also the need to emphasize the outcome of the treatments ordered. For instance, for those with a restricted calorie diet, was there a weight loss? ▪ The Facility rated itself as being in compliance with Section H.2. The Facility rated itself as being in noncompliance with Sections H.1, H.3, and H.4. This was consistent with the Monitoring Team's findings. It did not rate Sections H.5, H.6, and H.7. ▪ The Facility data did not identify areas in need of improvement. For those areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying for example PCP response to abnormal lab results, degree of treatment success (i.e., Hemoglobin corrected, intended weight loss, etc.).
	Summary of Monitor's Assessment: The Dental and Pharmacy Departments completed their required periodic assessments in a timely manner. The Medical Department continued to need improvement, although progress had been made for both annual exams and the quarterly medical reviews. The Facility did not yet have a process in place to accurately identify assessments needed for ISP meetings. QIDP Department staff recognized work was needed to ensure that when teams met for ISP Planning meetings they consistently identified necessary assessments based on individuals' needs and preferences, or that teams provided adequate justification for not requiring such assessments. There was continued auditing by external medical peer reviewers, as well as internal medical peer reviewers in determining whether the common elements of clinical care were occurring. Additionally, the Medical Department had begun to expand the number of internal quality monitoring tools, and had implemented a number of these over several months, with data that was analyzed. A strong quality improvement process needed to be demonstrated (i.e., was the analysis followed by identification of areas needing improvement, followed by evidence of development and implementation of a corrective action plan, followed by follow-up audits to determine impact of the implemented action plan). An expansion was needed of the areas measured for quality [e.g., not only were certain standardized tests ordered per diagnosis, but was there prompt and appropriate response to abnormalities (i.e., physical findings, lab tests, etc.)]. These also needed to be links to outcomes for individuals, and measurement of the efficacy of treatment. IHCPs were still not written in a manner that described all of the treatments and interventions that

	individuals required. Nor did the current IHCPs allow determinations to be made regarding whether or not such treatment and interventions were provided in a timely manner or if they were effective. When treatment was not effective, then teams needed to review treatments and consider modifying them, as appropriate.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>H1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.</td><td>Several routine and periodic assessments were reviewed for timeliness in submitted documents for several clinical departments. These included:
One hundred seventy of 240 (71%) medical annual assessments were completed in a timely manner within 365 days of the prior medical annual assessment. Two hundred three of 247 (82%) most recent medical annual assessments were completed within the prior 365 days of the Monitoring Team's visit.
One hundred forty of 142 (99%) annual dental evaluations were completed in a timely manner.
For the time period September 2013 through January 2014, 385 of 401 (96%) Quarterly Drug Regimen Reviews (QDRRs) were completed in a timely manner. In the most recent quarter submitted (October 2013 through January 2014), 325 of 325 (100%) of QDRRs were completed in a timely manner.
Departments were required to submit completed annual assessments 10 days prior to the ISP meeting date. The following is information the QA Department provided concerning compliance with timely submission of assessments for the ISP process:<table><tr><th>Department</th><th>September 2013</th><th>October 2013</th><th>November 2013</th><th>December 2013</th><th>January 2014</th><th>February 2014</th></tr><tr><td># of ISPs completed</td><td>21</td><td>23</td><td>14</td><td>17</td><td>19</td><td>19</td></tr><tr><td>Dental</td><td>20 (95%)</td><td>23 (100%)</td><td>14 (100%)</td><td>16 (94%)</td><td>19 (100%)</td><td>19 (100%)</td></tr><tr><td>Medical</td><td>18 (86%)</td><td>15 (65%)</td><td>5 (36%)</td><td>11 (65%)</td><td>13 (68%)</td><td>15 (79%)</td></tr><tr><td>Pharmacy</td><td>19 (90%)</td><td>21 (91%)</td><td>12 (86%)</td><td>16 (94%)</td><td>19 (100%)</td><td>19 (100%)</td></tr><tr><td>Psychiatry</td><td>20 (95%)</td><td>22 (96%)</td><td>12 (86%)</td><td>16 (94%)</td><td>19 (100%)</td><td>19 (100%)</td></tr><tr><td>Nursing</td><td>21 (100%)</td><td>23 (100%)</td><td>12 (86%)</td><td>14 (82%)</td><td>16 (84%)</td><td>18 (95%)</td></tr><tr><td>Occupational Therapy/Physical Therapy (OT/PT)</td><td>15 (71%)</td><td>12 (52%)</td><td>5 (36%)</td><td>13 (76%)</td><td>13 (68%)</td><td>19 (100%)</td></tr></table></td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Speech</td><td>19 (90%)</td><td>21 (91%)</td><td>11 (79%)</td><td>15 (88%)</td><td>17 (89%)</td><td>18 (95%)</td></tr>
<tr><td>Psychology</td><td>18 (86%)</td><td>9 (39%)</td><td>7 (50%)</td><td>8 (47%)</td><td>12 (63%)</td><td>15 (79%)</td></tr>
<tr><td>Dietary</td><td>16 (76%)</td><td>12 (52%)</td><td>5 (36%)</td><td>11 (65%)</td><td>7 (37%)</td><td>18 (95%)</td></tr>
</table>

Although work was needed to improve timeliness of assessments for ISP meetings, as discussed with regard to Section F.1.c, the Facility's data with regard to ISP assessments was not considered valid. The Facility did not yet have a process in place to accurately identify assessments needed for ISP meetings. QIDP Department staff recognized work was needed to ensure that when teams met for ISP Planning meetings they consistently identified necessary assessments based on individuals' needs and preferences, or that teams provided adequate justification for not requiring such assessments. The Facility remained in noncompliance with this provision.</td><td></td></tr>
<tr><td>H2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.</td><td>The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.</td><td>Substantial Compliance</td></tr>
<tr><td>H3</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and</td><td>The Medical Department had some mechanisms in place to ensure the provision of timely treatments and interventions. For example, the morning medical meeting was an interdisciplinary forum to address acute change of status of all individuals as problems arose. Change of status was discussed the next business day, with several routes to ensure timely intervention and/or treatment. A look-back record review was completed on hospital admission, ER visits, and Infirmary admissions to review timely treatment, as well as quality of care of the appropriate clinical disciplines. This information was discussed at the morning medical meeting as a follow-up. For those individuals hospitalized, a post-hospital ISPA process</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	diagnoses.	was required and they were presented at the morning medical meeting. However, as discussed with regard to Section G.1, these were not consistently completed timely, and as a result, it was not clear that individuals' treatment was timely modified. As a measure of timely quality treatment/interventions, the Medical Department utilized the results of the external and internal medical management audit. An internal medical management audit was completed for diabetes, osteoporosis, and pneumonia in September 2013. PCP compliance was 94 percent. An internal medical management audit was completed for seizures, constipation, and urinary tract infections (UTIs) in December 2013. PCP compliance was 93 percent. For the external audit in December 2013, compliance for these same diagnoses was 91 percent. Inter-rater reliability was 87 percent for these three diagnoses. Details of the external and internal medical peer review are provided in the discussions related to Sections L.2 and L.3. It was noted that the Monitoring Team member's interpretation of submitted data did not necessarily match the analysis the Medical Department provided. As discussed with regard to Section I, IHCPs were still not written in a manner that described all of the treatments and interventions that individuals required. Nor did the current IHCPs allow determinations to be made regarding whether or not such treatment and interventions were provided in a timely manner. Given that Section H addresses all clinical care, other Department's at the Facility will also need to focus their efforts in illustrating compliance with these requirements. The Facility remained out of compliance with this provision.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The Medical Department had created a number of additional quality medical care monitoring tools with specific measurable indicators. Several guidelines were written providing instruction on how to use the quality assurance tools. Copies of the tools were submitted, and they are discussed in more detail with regard to Section L.3. These guidelines included the following: ▪ Guidelines for using the Quality Indicators for UTI Monitoring Tool; ▪ Guidelines on when to develop an ISPA after a consult; ▪ Guidelines for using the Section L Vitamin D and Calcium Monitoring Tool; ▪ Guidelines for using the Quality Indicators for Diabetes Monitoring Tool; ▪ Guidelines for using the Quality Indicators for Hypertension Tool; and ▪ Guidelines for using the Quality Indicators for Constipation Monitoring Tool. The ER/Hospital Quality Indicators were implemented through a monthly audit for April through July 2013. This audit tool was then decreased in frequency to a quarterly tool due to compliance over 97 percent, providing the ability to implement a UTI quality indicator tool. Compliance data was summarized in bar graph format for each audit at periodic intervals per clinical indicator for several tools: Diabetes Quality Indicator Tool, Hypertension Quality Indicator Tool, Constipation Quality Indicator Tool, Osteoporosis Quality Indicator Tool, Seizure	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Quality Indicator Tool, and Down Syndrome Quality Indicator Tool. For each bar graph, a summary analysis was provided of the interpretation of findings and briefly addressed any areas identified needing improvement. These quality indicators focused on whether specific actions were taken for a diagnosis or hospitalization/ER visit. Focus was on ordering the appropriate consults, tests, IPN completion, etc. This reflected PCP completion of set criteria for standards of care. The clinical indicators chosen did not measure whether there was evidence of clinical improvement for a diagnosis or whether a health care goal had been achieved or maintained.

As is discussed in further detail with regard to Section I, to assess the efficacy of treatments, individual clinical indicators should be included in individuals' IHCPs and teams should regularly review the data collected to determine whether treatments are effective or need to be reviewed and revised, as appropriate. The Facility remained in noncompliance with this provision.</td><td></td></tr>
<tr><td>H5</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.</td><td>For the data the Facility submitted from August 2013 through February 2014, 343 of 564 (61%) active medical records included current medical quarterly notes. For the most recent month of data (February 2014), 55 of 91 (60%) of quarterly medical reviews were current. Based on the Facility's data, three hundred twenty five of 325 (100%) QDRRs were current.

Along with serial departmental assessments, the morning medical meeting each business day provided an up-to-date review of all acute health status changes for those individuals on campus as well as those hospitalized (i.e., individuals hospitalized, seen at the ER, or admitted to the Infirmary). This was done through the on-call PCP report, a review of the 24-hour log, the Infirmary admissions report, and the Hospital Liaison Nurse report. The handouts and minutes provided written documentation of review and discussion of each case. Open record reviews were assigned and reported at the morning medical meeting.

As part of the monitoring process, the morning medical meeting reviewed a number of clinical processes to monitor the health status of individuals. Per month, the following information was submitted:
<table>
<tr><th>Report</th><th>August 2013</th><th>September 2013</th><th>October 2013</th><th>November 2013</th><th>December 2013</th><th>January 2014</th></tr>
<tr><td># of consults reviewed</td><td>75</td><td>61</td><td>68</td><td>77</td><td>54</td><td>82</td></tr>
<tr><td>Open record reviews</td><td>4</td><td>7</td><td>5</td><td>5</td><td>9</td><td>8</td></tr>
<tr><td>ISPA completed</td><td>11</td><td>3</td><td>3</td><td>14</td><td>5</td><td>6</td></tr>
<tr><td># after hours breakthrough</td><td>Not available</td><td>Not available</td><td>51</td><td>43</td><td>30</td><td>45</td></tr>
</table></td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>seizures</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td># of individuals provided rescue medications for seizures</td><td>Not available</td><td>Not available</td><td>4</td><td>5</td><td>0</td><td>4</td></tr>
</table>

The Medical Department developed a protocol entitled: “Infirmary Observation for Fever and/or Unstable Vital Signs.” Once unstable vital signs were documented, the individual was transferred to the Infirmary for more intensive medical and nursing monitoring. From the data submitted, there were 25 Infirmary admissions from August 2013 through January 2014, based on implementation of this protocol. For these 25 individuals that were transferred to the Infirmary for more intensive monitoring, none were transferred to the hospital setting. At the Monitoring Team’s next visit, several additional months of data will have been collected, which will help to determine if this is a reproducible trend.

Listed under the Action Plans for Section H was the statement: “develop quality indicator Tools that measures efficacy of treatment (change of blood pressure, improvement of DEXA scores, Vitamin D levels, Hgb A1C).” The document indicated this action plan had “not started,” but the Medical Department is encouraged to develop such indicators.

Again, as discussed with regard to Section H.4, it will be important for teams to develop individual clinical indictors and to collect and assess data to identify more subtle changes in health status, and respond appropriately. The Facility remained in noncompliance with this provision.</td><td></td></tr>
<tr><td>H6</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.</td><td>The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.</td><td>Noncompliance</td></tr>
<tr><td>H7</td><td>Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall</td><td>The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	establish and implement Integrated Clinical Services policies, procedures, and guidelines to implement the provisions of Section H.		

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC's Self-Assessment; o CCSSLC's Section I Presentation Book; o CCSSLC At-Risk Individuals list; o For the following individuals' active records, selected documents: most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPN, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries past one year, ER report past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, integrated risk rating form past one year, most recent integrated health care plan for the following individuals: Individual #8, Individual #130, Individual #333, Individual #15, Individual #101, and Individual #335; and o The following documents: Integrated Risk Rating Forms, Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans/Integrated Health Care Plans for the following individuals: Individual #122, Individual #189, and Individual #86 for aspiration risk; Individual #348, Individual #238, and Individual #147 for behavior issues; Individual #79, Individual #275, and Individual #366 for constipation; Individual #369, Individual #268, and Individual #243 for falls; Individual #292, Individual #321, and Individual #290 for fractures; Individual #247, Individual #130, and Individual #239 for infections; and Individual #218, and Individual #78 for weight. ▪ **Interviews with**: o Colleen M. Gonzales, BSHS, Nurse Operations Officer (NOO); and o Rachel Martinez, QIDP Coordinator. ▪ **Observations of**: o ISP meeting for Individual #184, on 3/31/14; o ISP meeting for Individual #91, on 4/1/14; and o ISP meeting for Individual #268, on 4/2/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section I, in conducting its self-assessment: ▪ At the time of the review, the Facility was in the process of revising the Monthly Monitoring Tool for Section I, as well as developing formal instructions working off the previous tool, which included all the provisions of the Settlement Agreement for the different subsections of Section I. Based on a review of the Facility's Self-Assessment:

	○ Due to an extended leave of absence of the Section I Lead in December 2013, portions of the Facility's data were not accessible to the Facility staff. Some of the indicators the Facility used for this section, as well as some of the data presented were in alignment with the Monitoring Team's indicators and some of the findings. However, Facility staff indicated during the review that the quality of the documentation was not reflected in the data. As the Facility continues to revise and refine its monitoring tools, the Facility is encouraged to continue to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. In addition, adequate instructions are needed addressing methodologies to be used with regard to specific indicators, such as observations, record reviews, and specific criteria for compliance. In addition, further definition is needed with regard to the criteria auditors should use to rate the various indicators. Thus, there is a need for clear instructions for all monitoring tools and the establishment of inter-rater reliability to ensure the data generated from the tools are an accurate reflection of the area being audited. ○ Regarding identifying the sample and sample sizes, a description of the process for determining how the total population from which the samples were pulled (e.g., everyone with a completed risk rating tool, individuals identified with high-risk ratings, etc.) was included in the Facility's Self- Assessment. However, the sample was described as being for individuals with high-risk indicators while the data indicated that some individuals in the sample did not have high-risk indicators. After clearly identifying the total population (N) used to define the sample selected (n), an adequate sample size would be needed to consider the data representative of the actual practices being monitored. ○ Regarding the monitoring for Section I, in order for the Facility to generate accurate data reflecting the clinical quality of the documentation, auditors for this area should be deemed competent in the use of the tools and deemed programmatically/clinically competent in the relevant area(s). As noted during several past reviews and in the Monitoring Team's previous reports, the quality and adequacy of the audits conducted by a number of disciplines regarding the at-risk individuals were consistently found to be significantly inadequate. In order to ensure the accuracy of the data, the Facility should evaluate who would best audit this highly clinical area. In addition, in assessing quality of the documentation, the Facility should incorporate the use of nursing protocols and clinical pathways into the instructions to ensure that discipline-specific documentation is in alignment with the standards of practice for the particular discipline. ○ Adequate inter-rater reliability should be established for the final Section I monitoring tool. ▪ Due to the lack of an adequate written procedure addressing the process of developing and implementing monitoring tools, lack of established inter-rater reliability, and overall data presentation, the Facility did not yet have a consistent system for presenting data in a consistent and meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Did not present many findings based on specific, measurable indicators. For example, the Facility needs to be clear regarding what specific criteria had been used to determine compliance, especially regarding the quality of the documentation. As noted above, such

	criteria should be based on practice standards, such as nursing protocols, versus merely the completion of the documentation. The Facility rated itself as being in substantial compliance with none of the subsections of Section I. This was consistent with the Monitoring Team's findings. However, the Monitoring Team's findings addressed the quality aspect of the documentation reviewed. In reviewing the Monitoring Team's report, the Facility should determine how it will assess quality, and also identify reasons for any compliance score discrepancies found between the Monitoring Team and the Facility's data.
	Summary of Monitor's Assessment: At the time of the review, the Facility had experienced staffing challenges, including an extended leave of absence of the Section Lead for Section I. Unfortunately, this had resulted in data gaps for the review period, because data were not accessible to the Facility staff at the time of the review. In addition, the Facility had experienced a loss of some of the gains it had made at the time of the previous review in relation to the identification of key compliance indicators to measure the quality of the supports and documentation for Section I in alignment with the Settlement Agreement requirements. It is essential that the Facility designate a dedicated Section Lead for this area in order to continue to move forward regarding the at-risk system. On a positive note, the Facility had initiated a promising tracking system regarding changes of individuals' status at the residence level before individuals were admitted to the Infirmary or community hospital. Addressing changes in status at this point was the Facility's first step in ultimately being able to proactively provide supports of the needed clinical intensity to attempt to prevent acute illnesses that might require a transfer to another environment. In addition, in January 2014, the Facility had initiated the Assessment Review Committee to ensure individuals' strengths, preferences, and goals were included in assessments. Also, since the last review, the Facility developed a flow chart to assist the teams in determining what type of Individual Support Plan Addendum (ISPA) to initiate: a regular ISPA, Unusual Incident ISPA, or a Review for Change of Risk level. Although the Facility continued to invest a great deal of effort in building the At-Risk system at CCSSLC, there continued to be an overall lack of clear documentation included in the ISPs, the Integrated Risk Rating Forms (IRRFs), the Integrated Health Care Plans (IHCPs), and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues. Although the Monitoring Team observed some positive practices at the ISP meetings held during the onsite review, there continued to be significant problematic issues regarding the accuracy of the risk levels, the reflection in the IHCPs of supports of the necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this process.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Since the last review, interviews with the Facility staff, and CCSSLC's Self-Assessment indicated that the following steps had been implemented, and assessments conducted regarding the at-risk process: ▪ At the time of the review, the Facility had experienced staffing challenges, including an extended leave of absence of the Lead for Section I. Unfortunately, the Nurse Operations Officer reported that this issue had resulted in data gaps for the review period, because data were not accessible to the Facility staff at the time of the review. In addition, the Facility had experienced a loss of some of the gains it had made at the time of the previous review in relation to the identification of key compliance indicators to measure the quality of the supports and documentation for Section I in alignment with the Settlement Agreement requirements. The Facility is encouraged to ensure that criteria, such as nursing protocols and clinical guidelines/pathways, are included in the instructions of any auditing tools developed and implemented. The inclusion of such criteria is necessary to accurately assess compliance for any items addressing the quality of the supports and related documentation. At the time of the review, this important step had not occurred. It is essential that the Facility designate a dedicated Section Lead for this area in order to continue to move forward regarding the at-risk system. ▪ On a positive note, since the last review, the Facility had initiated a promising tracking system regarding changes in status at the residence level before individuals were admitted to the Infirmary or community hospital. Addressing changes in status at this point was the Facility's first step in ultimately being able to proactively provide supports of the needed clinical intensity to attempt to prevent acute illnesses that might require a transfer to another environment. ▪ In addition, in January 2014, the Facility had initiated the Assessment Review Committee to ensure individuals' strengths, preferences, and goals were included in assessments. ▪ Also, since the last review, the Facility developed a flow chart to assist the teams in determining what type of ISPA to initiate: a regular ISPA, Unusual Incident ISPA, or a Review for Change of Risk level. ▪ The Facility's Self-Assessment indicated that a review of 20 of 117 (17%) of the QIDP Coordinator's observations and review of ISP meetings held during the review period and documentation found: • Four of 19 (21%) ISP meetings had all appropriate disciplines present according to the ISP Preparation documentation that identified the appropriate disciplines; • 16 of 20 (80%) ISP meetings had the individual present according to the ISP signature sheet; • Three of 20 (15%) ISP meetings had participation by the guardians or	Noncompliance

#	Provision	Assessment of Status	Compliance
		family members; • 17 of 20 (85%) ISP meetings had the actual staff that worked with the individual present at the ISP meeting; • Six of 20 (30%) ISP facilitators kept the team focused as indicated by the QIDP facilitation tool; • 11 of 20 (55%) IDTs reviewed the necessity of referring the individual to the PNMT (or Behavior Support Committee) as needed; and • Eight of 20 (40%) ISP meetings had the PCP present. <u>Self-rating</u> The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in substantial compliance. The ISPs did not have all appropriate disciplines present, individuals present, PCP present, or the family or guardian present. Although we had a low percentage of guardian/family attendance, they are invited to the ISP Meeting six weeks in advance. In addition, the ISP facilitators did not keep the team focused during the ISP Meeting and they did not consistently initiate the review of referring the individual to PNMT or BSC. This provision will continue to be addressed through I.1 action plan, steps 6, 7, 8 and 9." To assess the Facility's risk screening process, members of the Monitoring Team observed three individuals' ISPs meetings (i.e., Individual #184, Individual #91, and Individual #268) while on site. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at all (100%) of the observed ISPs. ▪ The staff present at the ISP meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for all (100%) of the ISPs. ▪ The individual was present at all (100%) of the ISPs meetings observed. Individual #184 and Individual #268 attended their ISPs, although both came into the meetings after they had begun. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at two (67%) of the ISP meetings. Although it appeared the team used the guidelines for many of the risk ratings for Individual #184, this was not consistent. For example, Individual #184 met the criteria for a medium risk rating for choking, but the team identified a low risk rating. The team did not specifically discuss the guidelines or specify their justification for not adhering to them. Similarly, Individual #184 met the criteria for a medium risk rating for constipation/bowel obstruction, and although nursing recommended a medium rating, the team agreed to a low rating, because the PCP said he had "no bowel obstructions" in the last year. Based on the risk guidelines, this was not	

#	Provision	Assessment of Status	Compliance
		sufficient justification. ▪ The IDT consistently used supporting clinical data when determining risks levels for none of the ISPs observed (0%). The IDTs for Individual #184, Individual #91, and Individual #268 did not consistently use supporting clinical data when determining risk levels. Although data was included in the IRRFs for these individuals and was discussed, data was missing, or very general. For example, the IRRF noted that Individual #184 "typically has a BM [Bowel Movement] every 1-2 days, usually semi-soft"). However, no specific information was provided regarding the Individual's bowel habits. Also, lab values for Individual #184 were missing (e.g., no calcium or Vitamin D levels were cited, even though he was at high risk for osteoporosis). In addition, data was not compared from year to year. For example, although the IRRF for Individual #184 included the number of seizures for this year, there was no comparison to previous years. For Individual #268, there was no comparison of the current Braden score of 23 to the previous year's score, which was not included on the IRRF. ▪ Overall, the risk levels the IDT designated were appropriate for each category for two of the ISPs observed (67%) from information and data provided by the IDTs. As noted above, although Individual #184 met the criteria for a medium risk rating for constipation/bowel obstruction, he was rated low because the PCP said he had "no bowel obstructions" in the last year. In addition, the Behavioral Health rating for Individual #184 that should have been medium was identified as a low risk rating without reference to the guidelines, or justification for not adhering to the guidelines. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in one (33%) of the ISPs meetings observed. The individuals' IDTs that did not have adequate and appropriate clinical discussion among team members included Individual #184 and Individual #91 (as discussed in further detail below). ▪ Team disagreements regarding risk levels were noted in none of the ISP meetings, so there was no need to determine whether or not they were resolved based on appropriate clinical information. However, there should have been respectful disagreements for Individual #184. The team did not challenge one another when they should have. ▪ Based on all ISPs observed by the Monitoring Team, the ISP facilitators kept the team focused in all three (100 %) of the ISPs meetings observed. In addition, other positive observations from the Monitoring Team included: ▪ Individual #184's team had good discussion of the causes of his falls and possible solutions. For example, one potential cause was Individual #184 not leaving his seatbelt fastened, and falling forward out of his wheelchair when reaching for items. The team discussed the possibility of developing a	

#	Provision	Assessment of Status	Compliance
		reinforcement to increase his use of the seatbelt, and the Behavioral Health Services team member agreed to develop a plan that would utilize intermittent reinforcement. The team specifically discussed incorporating some of Individual #184's preferences into the plan. ▪ The QIDP for Individual #184 facilitated incorporation of various pieces into integrated plans, such as including communication supports with behavioral supports. In addition, as noted above, behavioral supports were included in the plan to address falls. OT/PT supports also were included, because the team believed that another cause of falls might be that he tipped sideways in his wheelchair. OT/PT staff were included in the plan to assess whether widening the base of his wheelchair and/or adding tilted wheels would help. ▪ For Individual #184, the team discussed the Psychoactive Medication Treatment Plan, including the potential and realized side effects. ▪ The team for Individual #268 had good discussions regarding the use of Social Stories in addressing his behaviors of stealing things from others. Information was provided by the SLP regarding the positive outcomes from the past use of a Social Story for dental issues for the individual. ▪ The psychiatrist for Individual #268 brought up a number of important clinical issues regarding Individual #268's medication regimen and his sleep issues. ▪ The team for Individual #268 added a lengthy list of the individual's strengths to the ISP, illustrating that they were very familiar with him. ▪ For Individual #91, the team discussed the content of IHCP at the end of each section of the IRRF and made additions, when necessary. ▪ The team for Individual #91 appropriately referred to the Risk Guidelines as they worked to assign a risk level. Problematic areas needing focus or improvement included: ▪ The team for Individual #91 did not review the Integrated Health Care Plans and/or make revisions based on the team's discussion. Despite the QIDP Coordinator, who was observing, prompting the team to review the IHCPs, they did not. The team did not discuss measurable objectives or clinical indicators to assist them in determining whether Individual #91 was remaining stable, doing better, or doing worse. ▪ Individual #184's team did not discuss measurable goals and objectives to determine whether he was improving, regressing, or remaining stable. This needs to be the responsibility of the entire team, and needs to be done for all of the action plans, including IHCPs. ▪ Although Individual #184 required pre-treatment sedation, the team did not specifically discuss a desensitization plan or other strategies to reduce the need for sedation. ▪ For Individual #184, the team identified that the behavioral data was not	

#	Provision	Assessment of Status	Compliance
		accurate. However, the team did not develop a plan to improve the quality of the data. ▪ Individual #91's team did not discuss the inclusion of individual-specific triggers in appropriate risk categories to alert staff to a change in status (e.g., choking, aspiration, cardiac, infections, UTIs). ▪ The team for Individual #91 did not consistently present sufficient clinical data to support the rationale for each risk rating. In many cases, the team's rationales were simply a re-statement of indicators on risk guidelines. ▪ A draft copy of the IHCP was not available to IDT members during Individual #91's ISP meeting. ▪ The IHCP discussions for Individual #268 did not include the implementation of nursing protocols for his identified health concerns. ▪ The team for Individual #268 did not integrate most of his preferences and strengths into their overall discussions. Although his preference for tractors, trains, and trucks were frequently acknowledged, most of his other personal preferences and strengths were not included in the discussions. From the Monitoring Team's observations and record reviews, the Facility continued to make some positive steps forward regarding the structure and format of the ISP meetings. However, more efforts are needed to ensure that the risk levels are accurate, that the IHCPs reflect the needed clinical intensity in alignment with the appropriate designated risk levels and include nursing assessments in alignment with nursing protocols, that objectives included are functional and/or measurable, that adequate preventative measures are discussed and are included in the integrated health care plans, and teams clearly document this process. The Facility remained out of compliance with this provision.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being	The Facility's Self-Assessment for this provision indicated that a review was conducted of 20 of 117 (17%) Annual Nursing Assessments, Annual Medical Assessments, and Integrated Risk Rating Forms from 8/1/13 through 1/31/14, and found the following: ▪ 17 of 20 (85%) Annual Nursing Assessments were completed and posted within 10 days of the annual ISP date; ▪ Three of 13 (23%) of the Annual Comprehensive Nursing Assessments contained an adequate assessment of the specific high-risk health indicators or provided some type of analysis of the high-risk health indicators in the Summary Section (seven of the 20 did not have high-risk indicators); ▪ 10 of 20 (50%) Annual Medical Assessments were posted in the shared drive at least 10 days prior to the ISP; ▪ Zero of 13 (0%) of the Annual Medical Assessments contained an adequate assessment of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators (seven of the 20 did not have high-risk	Noncompliance

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	identified as at risk.	indicators); and ▪ Nine of 20 (45%) Integrated Risk Rating Forms were completed within 10 days of the scheduled ISP date. <u>Self-Rating:</u> The Facility indicated that: "based on the findings from this self-assessment, this provision is not in substantial compliance. The Annual Nursing Assessment improved in being completed 10 days prior to the ISP however they did not contain adequate analysis. The Medical assessment form was implemented in January 2014 campus wide. Furthermore the IRRF was not consistently completed 10 days prior to ISP date. This provision will continue to be addressed through I.2 action plan, step 1 and 4." Based on a review of records for 20 individuals determined to be at risk (i.e., Individual #122, Individual #189, and Individual #86 for aspiration risk; Individual #348, Individual #238, and Individual #147 for behavior issues; Individual #79, Individual #275, and Individual #366 for constipation; Individual #369, Individual #268, and Individual #243 for falls; Individual #292, Individual #321, and Individual #290 for fractures; Individual #247, Individual #130, and Individual #239 for infections; and Individual #218, and Individual #78 for weight), there was documentation that the IDT started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for none of these (0%) individuals. Problematic issues that resulted in noncompliance included: ▪ Integrated Risk Rating forms did not consistently include specific clinical data, such as the number of bowel medications and supplemental laxatives/stool softeners regarding constipation risks, or dates and the types of injuries/fractures when addressing falls, to support the risk ratings for the health indicators as compared to clinical data from the previous year. As a result, it was unclear whether further assessment was needed; and ▪ When recommendations for further assessment were found in the IHCPs, the date of completion was frequently left blank. Thus, it was impossible to determine what precipitated the recommended assessment, and if it was actually timely completed. <u>Nursing Assessments</u> Based on a review of 20 individuals' records for which assessments were to be completed to address the individuals' at risk conditions, three (15%) included an adequate assessment of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form (i.e., Individual #122, Individual #189, and Individual #86). From a review of these nursing assessments, it was clear that the Facility was in the process of focusing its efforts on improving the documentation contained in the	

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		Comprehensive Nursing Assessments. Improvement, although not consistently found in all the assessments the Monitoring Team reviewed included using some of the past quarterly or annual information and providing an update regarding the current status of the health risk indicators. However, more work was needed regarding the analysis of the information. More specific details are provided with regard to Section M.2. In addition, regarding the Integrated Risk Rating forms, a review of these 20 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. Although the Monitoring Team found that there continued to be an overall increase in some of the specific clinical information contained on the IRRF forms, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, and falls, injuries and/or fractures, there was a lack of individual-specific information from the previous year that made it difficult to determine the accuracy of the risk rating that was assigned. <u>Medical Assessments</u> Based on review of six individuals' records (i.e., Individual #8, Individual #130, Individual #333, Individual #15, Individual #101, and Individual #335), there appeared to be gaps in assessment, treatment, documentation, and/or follow through to closure. Many of these areas required the cooperation and follow through of the Medical Department as well as other Departments. Two examples are provided in detail: ▪ On 5/6/13, Individual #130 underwent an EGD and had a gastrostomy tube replaced. On 9/10/13, it was replaced again, and the external bumper was to be monitored to ensure it did not migrate internally and cause a gastric outlet obstruction. On 9/28/13, he then was hospitalized for aspiration pneumonia, and on 12/16/13, he was discharged home from the Infirmary. An ISPA of 12/16/13 did not provide guidance regarding steps to prevent another aspiration pneumonia. The need for timely positioning, the need for monitoring of positioning, the need for the PNMT to review the most appropriate angle for elevation of the head of the bed, and the need to improve his oral hygiene rating that was rated as poor on 1/16/14, were not discussed. Historically, he had GERD and was placed on a proton-pump inhibitor (PPI). He had a history of gastric distention. The date of determination of these diagnoses was not available, but a timely review of the severity of the individual's GERD and gastric emptying would be helpful. The individual might be a candidate for a fundoplication, but there did not appear to be discussion of this option. He had a fracture tibia/fibula on 1/28/14, and the radiologist mentioned potential osteopenia. He was non-ambulatory prior to the fracture. Despite the	

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		significant risk of osteoporosis, as of the date of the Monitoring Team visit, the individual had not completed a DEXA scan. One had been ordered for March 2014, but was cancelled, because he had not been kept "nothing by mouth" (NPO). The fracture occurred on the second shift, and there was no discussion whether the staff on that shift needed refresher training using the proper lift with him, or whether staffing was sufficient to meet his needs. He had several risk factors for osteoporosis that included being prescribed life-long antiepileptic medication (i.e., currently prescribed Dilantin), congenital hip deformities, and spastic quadriparesis. It is recommended that the Medical Department review the individual's high risk for osteoporosis and considers a DEXA scan and indicated treatment based on these results, rather than waiting for a fracture to occur. He was hospitalized on 2/13/14 for a bowel obstruction and found to have a fecal impaction. The ISPA of 2/26/14 did not address steps to prevent another fracture nor how to prevent another fecal impaction. When the individual was discharged from the hospital after treatment of fecal impaction, there did not appear to be any increase in medication or discussion of the need for colon motility studies to determine next step, whether medical or surgical. Without significant additional steps, the risk of recurrent fecal impaction is a high risk. ▪ Individual #333 had not walked for several years, and also sustained a hip fracture. Despite other risk factors, because of the young age (i.e., 28), there had not been a consideration of osteoporosis, and there were no DEXA scan reports to review. He had a seizure disorder and required three anti-epileptic medications and a vagus nerve stimulator (VNS) to improve control of his seizures. Again, it is recommended that a protocol or other systems approach be developed to ensure that individuals at risk for osteoporosis at an early age are identified, and once identified, the potential diagnosis of osteoporosis or osteopenia is confirmed or ruled out with a DEXA scan, and for those with a diagnosis, an aggressive medical management to prevent fractures is implemented. The individual had a gastrostomy tube (G-tube) placement due to meal refusal and refusal to take medication. He had demonstrated ability to eat fast food without problems, but had a long history of meal refusal at CCSSLC. He had a history of oral dysphagia and required a chopped texture diet with thin liquids. On 8/9/11, he had a gastrostomy tube placement for inability to consume sufficient nutrition. It was noted that in January 2012, he was discharged from psychiatry clinic. On 8/14/12, an esophagogastroduodenoscopy (EGD) was completed with the finding of a small sliding hiatal hernia and gastritis, but no cause for the recurrent vomiting. He was H pylori negative. There was no	

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		Barrett's esophagus. There appeared to be several areas needing review and further assessment, based on the limited information submitted for review. That a psychiatrist had not been involved in his care since January 2013 was problematic. Although there might be difficulty with examination, depression needed to be ruled out as a contributing factor for his lack of interest in food, although it was specific to Facility food. The Pharmacy Department needed to review his medication profile to rule out any medications contributing to potential loss of the sense of taste or smell, anorexia, and irritability. Habilitation Therapy needed to conduct an extended open record review to determine the level of independent ambulation in the past, and to review causative factors if there had been a decline, with steps to reverse the process of lack of ambulation. It could not be determined from the submitted information whether the VNS could be contributing to coughing or vomiting. A speech therapist or ENT specialist might provide guidance in those with loss of taste and smell or with altered senses that might contribute to a lack of interest in eating. A dietary consult was needed to determine what his favored off-site foods were and the differences with what was being offered in the residence. This could be due to the aroma of the food, the packaging/wrapping of the food, the mealtime environment (i.e., sitting at a table with music in the background, etc.), the size of the meal, the visual first impression of the meal, the salt content, etc. The IDT should take steps to ensure his swallowing function is maintained and does not degenerate due to lack of regular eating. Referral to a tertiary care center for a second opinion about his anorexia or behaviors might be indicated if the IDT has investigated all areas they believe are contributing to the meal refusal and have not found a correctable cause. Both cases demonstrated the need to improve on the interdisciplinary approach in resolving/preventing recurrence of issues. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area. This was consistent with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen	The Facility's Self-Assessment indicated that a review conducted on 20 of 117 (17%) IHCPs from 8/1/13 through 1/31/14 found the following: ▪ 11 of 20 (55%) IHCPs identified a high-risk indicator; ▪ Seven of 11 (67%) of the IHCPs included preventative interventions in the plan to minimize the condition of risk;	Noncompliance

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	days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	▪ Eight of 11 (73%) of the IHCPs demonstrated adequate integration between all of the appropriate disciplines, as dictated by the individual's needs; ▪ Six of 11 (55%) of the plans had measurable objectives and clinical indicators established; ▪ Four of 11 (36%) identified the frequency of monitoring by shift and day; and ▪ One of 11 (9%) action steps included in the IHCPs were implemented as identified by the IDT. <u>Self-Rating:</u> The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in substantial compliance because the IHCP system although improved is not consistent in addressing individuals risk needs. This provision will continue to be addressed through Action Plan I.3, steps 1-4." Based on a review of 20 records for individuals determined to be at risk (i.e., Individual #122, Individual #189, and Individual #86 for aspiration risk; Individual #348, Individual #238, and Individual #147 for behavior issues; Individual #79, Individual #275, and Individual #366 for constipation; Individual #369, Individual #268, and Individual #243 for falls; Individual #292, Individual #321, and Individual #290 for fractures; Individual #247, Individual #130, and Individual #239 for infections; and Individual #218, and Individual #78 for weight), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). Although all 20 individuals were found to have an Integrated Health Care Plan addressing their high or medium health/mental risk indicator in the Active Record, none sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 20 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some ISPs addressing, for example, the need to encourage adequate fluids and exercise, because these interventions were not written in measurable terms to	

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		allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the IHCP into the ISPs in 20 of the 20 cases (100%). ▪ None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability, or it was not addressed. At the time of the review, the Facility indicated it was not in compliance with the requirements of the Settlement Agreement for this area. This finding was consistent with the findings of the Monitoring Team. CCSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate Comprehensive Nursing Assessments as well as Integrated Health Care Plans.	

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Policies related to the use of pre-treatment sedation medication; o Spreadsheet of individuals who have received pre-treatment sedation medication in the last six months for medical or dental procedures, name and dosage of medication, including date of administration; o Job descriptions of Psychiatrists; o List of individuals whose psychiatric diagnoses have been revised, along with the Psychiatrist's rationale for the new diagnosis; o List of individuals prescribed intra-class polypharmacy, with total number of medications prescribed; o List of all meetings and rounds that the Psychiatrists typically attend, including other professional disciplines that usually attend those meetings; o List of support services for Psychiatry Department; o Minutes of Polypharmacy Meeting Review for the last six months; o In response to Monitoring Team's request for documentation pertaining to complaints about the psychiatric and medical care at CCSSLC, documents indicating no complaints; o Materials distributed at the Pharmacy & Therapeutics (P&T) Committee Meeting, on 4/1/14; o Lists of individuals with tardive dyskinesia, and individuals being monitored for tardive dyskinesia; o List of all individuals prescribed psychotropic medication, including diagnosis, name of medication, and dosage; o List of all individuals prescribed anticonvulsant medication as a psychotropic medication; o List of individuals who were psychiatrically hospitalized within the prior six months; o List of Individual Support Plan (ISP) meetings attended by members of the Psychiatry Department within the prior six months; o Consent database for psychotropic medication; o Chemical restraint trending data for the last six months, and the chemical restraint administration documentation for the last six months; o Comprehensive Psychiatric Evaluation (CPE) completion status spreadsheet and ten examples of recently completed CPEs; o Spreadsheet listing the individuals who are followed in the Neurology Clinic with notation as to which individuals are also followed by Psychiatry, and the date of recent visit to Neurology Clinic; o Neurology Clinic notes and the corresponding Quarterly Psychiatric Clinic notes for ten individuals jointly followed by Neurology and Psychiatry who were reviewed in

	the 2/12/14 and 2/13/14 Neurology Clinics; o Spreadsheet of Reiss Screen Examinations for all CCSSLC individuals, and the CPEs for those individuals that had an elevated score and were not followed in the Psychiatric Clinics; o List of individuals receiving anticholinergic medication; o List of individuals prescribed benzodiazepines; o The sections from the active records as follows: Face Sheet, Social History, Rights Assessment, Consents for Psychotropic Medication, Consents for Pre-treatment Sedation Medication, Human Rights Committee (HRC) section and Referral Form, as well as Addendums related to Psychotropic Medication, ISP, the Individual Support Plan Addendums (ISPAs), Hospital section, Psychiatry section, Side Effect section, Pharmacy section, and the Neurology Consultation section, for the following individuals the Facility selected: Individual #177, Individual #295, Individual #12, Individual #255, Individual #78, Individual #292, Individual #354, Individual #315, Individual #92, and Individual #343; o The same documents from the active record, as listed above, for the following six individuals who were selected during the Monitoring Team's onsite review: Individual #325, Individual #298, Individual #296, Individual #273, Individual #16, and Individual #141; o The master spreadsheet for completion of the Monitoring of Side Effects Scale (MOSES) and the Dyskinesia Identification System: Condensed User Scale (DISCUS) for the last six months; o List of individuals receiving Reglan as of 4/1/14, and who were not prescribed psychotropic medication; o Curriculum Vitae (CV) and Contracts for the following: Dr. Gollavelli Krishna, Chief of Psychiatry Services, Dr. Michael Hernandez, Consulting Psychiatrist; and, Dr. Kurt Cousins, locum tenens Psychiatrist; o MOSES and DISCUS side effect rating scores for the last year for the following three individuals receiving Reglan who were not also receiving a psychotropic medication: Individual #366, Individual #127, and Individual #301; o CCSSLC Presentation Book for Section J - Psychiatric Services, which contained the following sections: a) Compliance Review; b) Plan of Improvement; c) Monitoring Tools; d) Evidence J.1 through J.15; and e) Recommendations one through three and Recommendations seven through 10; o Restraint documentation related to the administration of the following five incidents of chemical restraint and the (date): Individual #253 (3/10/14), Individual #50 (2/23/14), Individual #237 (12/6/13), Individual #40 (3/1/14), and Individual #40 (12/10/13); o Clinical documentation related to the 4/2/14 Psychiatric Clinics; o Data related to the Quality Assurance Department's ongoing assessment of the Psychiatry Department's progress in meeting the requirements of the Settlement Agreement;

	○ List of Individual Support Plan Meetings a member of the Psychiatry Department attended within the last 12 months, including date of the ISP Meeting and the member of the Psychiatry staff that attended the meeting; ○ Analysis of the allocation of time commitments of the Psychiatrists who work at CCSSLC; ○ Psychiatric Symptoms and Target Behaviors Flow Sheet; ○ Chemical Restraint Trending Data for the last year; ○ Spreadsheet listing individuals deemed to not be appropriate for a Desensitization Plan; ○ Documentation of the training that nursing staff received with regard to completing the DISCUS evaluations; ○ Consent packets for psychotropic medications for the individuals reviewed during the Human Rights Committee Meeting, on 4/2/14; ○ Consent Tracking database/spreadsheet maintained by the Psychiatry Department; ○ A blank copy of the policy/shells revised on Psychiatric Symptom Tracking; ○ Most recent standardized CPE template; ○ The Psychotropic Medication Treatment Plan (PMTP) and the ISP for the following ten individuals: Individual #88, Individual #39, Individual #60, Individual #275, Individual #321, Individual #95, Individual #53, Individual #7, Individual #144, and Individual #153; ○ Ten recently completed CPEs that did not overlap with the 17 individuals in the sample; and ○ The most recent Neurology Consultation Note and related psychiatric documentation for the following individuals: Individual #292, Individual #16, Individual #372, Individual #269, Individual #19, Individual #136, Individual #268, Individual #45, Individual #311, and Individual #78. ▪ **Interviews with**: ○ Joseph Ward, Behavioral Health Specialist; Michael Hernandez, M.D., Consulting Psychiatrist; Glynn J. Bogard, Psychiatric Assistant; Michelle P. Lord-Arteaga, Psychiatric Nurse; Gollavelli J. Krishna, M.D., Chief of Psychiatry; Ingela Danielsson, M.D., Medical Director; Ruthlane Lopez, Psychiatric Nurse; Sara Perez, Behavioral Health Assistant; and Kurt L. Cousins, M.D., on 3/31/14; ○ Gollavelli J. Krishna, M.D., Chief of Psychiatry; and Kurt Cousins, on 3/31/14; ○ Glynn J. Bogard, Psychiatric Assistant; Michelle P. Lord-Arteaga and Ruthlane Lopez, Psychiatric Nurses; and Gollavelli J. Krishna, M.D., Chief of Psychiatry, on 4/1/14 and 4/2/14; ○ Michelle P. Lord-Arteaga, Psychiatric Nurse; Ruthlane Lopez, Psychiatric Nurse; and Gollavelli J. Krishna, M.D., Chief of Psychiatry, on 4/3/14; ○ Carolyn Milton, Director of Behavioral Services; Gollavelli J. Krishna, M.D., Chief of Psychiatry; Glynn J. Bogard, Psychiatric Assistant; Everett Bush, Behavior Analyst I; and Sara Perez, Behavior Health Assistant, on 4/1/14; ○ Gary Frech, Pharmacist In Charge; Jennifer Thompson, Clinical Pharmacist, and Amy

	Isaacs, Pharmacist II, on 3/31/14; ○ Enrique Venegas, D.D.S.; and Kathy Roach, Dental Hygienist, on 3/31/14; ○ Brief discussion with Karen Forrester, Human Rights Officer, and Glynn Bogard, Psychiatric Assistant, prior to the HRC Meeting, on 4/2/14; ○ Glynn Bogard, Psychiatric Assistant; Araceli Matehuala, Program Compliance Monitor for Psychiatry; Gollavelli Krishna, M.D., Chief of Psychiatry; and Michelle P. Lord-Arteaga, Psychiatric Nurse, to review Facility Self-Assessment, on 4/2/14; and ○ Glynn Bogard, Psychiatric Assistant; Michelle P. Lord-Arteaga, Psychiatric Nurse; and Gollavelli Krishna, M.D., to review the Psychiatry Department's status regarding the 15 provisions of Section J, on 4/3/14. ▪ **Observations of**: ○ Pharmacy and Therapeutic Committee Meeting, on 4/1/14; ○ Psychiatric Clinic, on 4/2/14; ○ Polypharmacy Committee Meeting, on 4/1/14; ○ HRC Meeting, on 4/2/14; ○ The following individuals were observed during the Monitoring Team's onsite review of the residences and program sites: Individual #267, Individual #159, Individual #20, Individual #53, Individual #325, Individual #39, Individual #95, Individual #336, Individual #172, Individual #92, Individual #238, Individual #167, Individual #118, Individual #312, Individual #300, Individual #158, Individual #174, Individual #275, Individual #7, Individual #35, Individual #98, Individual #296, Individual #138, Individual #308, and Individual #218.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J, dated 3/7/14. In its Self-Assessment, for each subsection, the Facility identified: 1) activities used to conduct the Self-Assessment; 2) the results of the Self-Assessment; and 3) a self-rating. On 4/2/14, a member of the Monitoring Team met with the Program Compliance Monitor, two Psychiatric Nurses, the Chief Psychiatrist, and the lead Psychiatric Assistant. Based on a review of the Facility Self-Assessment, the audit template guidelines, a sample of completed monitoring tools, inter-rater reliability data, as well as the meeting mentioned above, a member of the Monitoring Team made the following observations: ▪ The audit tool for Section J was developed within the Facility, but was derived from the audit tool DADS State Office developed. An additional methodology the Facility utilized included review of longitudinal spreadsheets/databases that were continuously updated. The specific application of these methods is described below. ▪ These monitoring tools included indicators to allow the Facility to determine compliance with the Settlement Agreement, if they were consistently applied to a large enough sample with adequate determination of inter-rater reliability between multiple raters. ▪ The monitoring tools consisted of methodologies that included an analysis of item-specific, cross-sectional data, which utilized a large number of records, as described below. Another corollary methodology utilized databases to monitor the Psychiatry Department's progress toward

	completing specific evaluations for all individuals who were prescribed psychotropic medication. ▪ The Self-Assessment identified the sample(s) sizes, including the number of individual records reviewed, in comparison with the number of individual records in the overall population. This sample size was adequate to consider them representative samples. The sample size of four per month would equate to 48 per year, which is 46 percent of 105 individuals prescribed psychotropic medication. ▪ During the 4/2/14 meeting related to this subject, the PCM, the Psychiatric Nurses, Psychiatric Assistants, and the Chief Psychiatrist, reviewed the current progress for the monthly Quality Assurance Reviews of individual records. Every month, four individual records were selected and distributed for review, including one each to the two Psychiatric Nurses, and one each to the two Psychiatric Assistants. The PCM reviewed two of these while blind to the other ratings. The data derived from this process was used to establish inter-rater reliability. The simple percentage congruence ratings ranged from 50 to 100 percent. The lead Psychiatric Assistant also performed sample-based, cross-sectional analyses for specific provisions. Only this individual completed those reviews. ▪ The monitoring tools had guidelines to ensure consistency in monitoring results, as they were directly derived from the language of the Settlement Agreement. However, there was no comprehensive instructional manual that included specific instructions to determine the validity of the methods, such as the review of specific documents, standards of quality, required sample size, and the necessary degree of inter-rater reliability. However, the questions were clearly designed to measure necessary components directly related to the Settlement Agreement. The questions were also constructed in a dichotomous yes/no format. ▪ The following staff members were responsible for completing the audit tools: the PCM assigned to the Psychiatry Department, the two Psychiatric Nurses, and the two Psychiatric Assistants. The item-specific, cross-sectional analyses referred to above were performed only by the lead Psychiatric Assistant. The review of longitudinal databases used for many sections were a joint effort between the Psychiatric Nurses and the Psychiatric Assistants. ▪ The Psychiatry Department staff members responsible for conducting the audits appeared to be clinically competent in the area(s) of the auditing process for which they were responsible. However, the Facility did not have a separate process for assessing the competency of the individuals to complete these audits in a reliable and valid manner. The PCM attended Polypharmacy Meetings and attended Psychiatric Clinics to the extent possible in order to become more knowledgeable about the clinical issues and processes. This staff member did not score items that would require clinical expertise to make an initial assessment of quality, but did score for the presence or absence of items. For example, the PCM would score for consistency of the psychiatric diagnosis between different sections of the record, but would not comment on the validity of that diagnosis. However, with the progression of time and continued refinement of the audit tool, these reviews had become more sophisticated, as the Facility's inclusion of psychiatric diagnostic checklists increased the validity of the review process. The PCM also checked to make sure the DADS policy related to specific provisions was followed. For example, with regard to documentation from a Neurology Consultation, she would check to see if it occurred in a timely manner and if the referral question was addressed in the Consultation. The lead Psychiatric

	Assistant had several years of experience, as well as a doctorate degree in a related field and was qualified to make decisions about the quality of the documents reviewed. The Psychiatric Nurses also had received specialized training in Psychiatry. ▪ Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. As indicated above, the Facility was not suggesting that the current scores were sufficient to make a statistically valid determination of inter-rater reliability, and instead were presented as simple rates of percentage agreement, which were sufficient for these purposes. ▪ In addition to the audits of the cross-sectional samples, the Facility used other relevant data sources. Specifically, the Psychiatry Department maintained detailed databases related to specific documents, such as the CPEs and the diagnostic checklists used to establish the psychiatric diagnosis (Sections J.2, Section J.6, and Section J.13); the polypharmacy statistics (Section J.11); the MOSES/DISCUS monitoring (Section J.12); the Reiss Screening evaluations (Section J.7); the specifics of Neurology Consultations (i.e., name, date, date of Consultation, date of Psychiatry Review) (J.15); the attendance of Psychiatric team members at ISPs and the Behavioral Support Committee Meetings (Section J.8, Section J.9, and Section J.10); and the changes in psychiatric diagnosis and the coordination of the multidisciplinary team input into the record for pre-treatment sedation when needed. They were able to utilize this information to document completion rates for the entire population of individuals receiving psychotropic medication. In addition, the Facility had engaged in an external peer-review exchange with another SSLC. This involved the utilization of a tool developed by DADS Central Office to score CPEs for necessary components (Comprehensive Psychiatric Evaluation Monitoring Tool). This instrument encompassed 16 weighted items specific to the CPE, and to be considered adequate, a weighted score of 80 out of a possible 100 was required. ▪ The Facility generally presented data in a useful way. Specifically, their use of longitudinal databases, which reported the completion rates for items such as the MOSES/DISCUS administration, CPE completion statistics, and the administration of the Reiss Screening instrument, produced a simple, straightforward means of assessing progress. The reports of the cross-sectional samples referenced above were also straightforward. However, it was not clearly stated that only one rater completed cross-sectional studies, and there was no attempt at describing inter-rater reliability for those. The PCM also prepared Quarterly Compliance Monitoring Reports based on the records she reviewed. The compliance ratings provided in the report were based on the overall compliance for the records reviewed, and the also included the inter-rater reliability ratings between the PCM and the Department. ▪ The Facility organized its self-assessment around specific indicators derived from the Settlement Agreement and the Monitoring Team's prior reports. ▪ The Facility rated itself as being in substantial compliance with 13 subsections of Section J. The exceptions were Section J.3 and Section J.4. ▪ The Facility's ratings and those of the Monitoring Team differed only for Sections J.8, J.9, and J.10. The reasons for these discrepancies are detailed in the narrative e sections of this report. The deficiencies primarily related to the lack of sufficient discussions related to this information in the annual ISP.

	▪ The Facility data identified areas for improvement. The Facility Self-Assessment provided some limited analysis of the information. This identified potential causes for the issues, but did not perform a detailed, root-cause analysis.
	Summary of Monitor's Assessment: The Monitoring Team conducted a streamlined review of Section J due to previous sequential substantial compliance ratings for five of the 15 subsections. Specifically, no monitoring was conducted of Sections J.1, J.2, J.6, J.7, and J.12. The following summarizes the Facility's status with the remaining provisions in functional categories. Section J.5: This provision relates to the quantity of the psychiatric staff. Previous calculations indicated that two full-time equivalent (FTE) Psychiatrists would be adequate to provide psychiatric services to the 105 individuals receiving psychiatric medication. The current group of Psychiatrists collectively accounted for 2.25 FTEs. In addition, the Chief Psychiatrist stated she had viable candidates for the open Psychiatrist block. Section J.13: This section addresses psychiatric diagnoses and the Quarterly Review process. The psychiatric diagnosis was discussed in multiple places in the record. The Psychiatry Department actually replicated the relevant Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) criteria that substantiated individuals' diagnoses. The spreadsheet the Psychiatry Department maintained to track the status of the CPEs indicated that all of the annual updates were current. Quarterly reviews were conducted timely, and included the necessary components. Section J.4: This provision relates to the use of pre-treatment sedation for medical and dental procedures. The Facility still had considerable work to do in this area, because at the time of the onsite review, there were only 11 Pre-treatment Desensitization Plans implemented, and all related to dental visits, and none addressed the need for medical pre-treatment sedation. Section J.10 and Section J.14: These two provisions address the related areas of risk-versus-benefit analysis and informed consent. A member of the Monitoring Team was able to attend the HRC meeting that took place during the onsite review and found the discussions to be thorough. The Pharmacy Department also provided another level of review of the consent process, in that they did not dispense a new psychiatric medication unless they physically saw a copy of the signed consent form. The current review found that the consent process was being uniformly implemented. Section J.3, Section J.8, and Section J.9: These provisions relate to the collaboration between the Psychiatry Department and the Behavioral Health Services Department. However, the language of these provisions also refers to the quality of the documentation contained in the ISPs, as well as the discussions that occurred during the ISP meetings. The spreadsheet the Facility maintained indicated that from 8/1/13 to 4/2/14, a member of the Psychiatry Team had attended 64 of 68 (94%) of the ISPs for the individuals they follow. A member of the Monitoring Team requested an expanded sample of ISP documentation to bring the review sample to 25 percent, in

	order to check for quality and verify the accuracy of the spreadsheet. The documentation in the ISP had improved considerably since the Monitoring Team's prior review. However, there were continuing concerns about the documentation of the actual discussions that took place during the ISP meetings. Section J.7, Section J.11, and Section J.13: The remainder of the provisions relate to various important aspects of psychiatric practice, such as polypharmacy. A member of the Monitoring Team attended the Polypharmacy Meeting during this onsite review, and the rates of polypharmacy continued to decline. The Department also had assembled convincing evidence for those whose medication regimens they believed could be clinically justified. Overall, the Facility had maintained the progress observed in the Monitoring Team's prior reviews, and also made progress in additional areas. The specific findings are discussed in the narrative review that follows.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for at least three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for at least three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately,	The individual interviews with members of the Psychiatry Department, as well as the review of the records of 16 individuals prescribed psychotropic medication did not reveal any evidence that psychotropic medication was being overtly used for the convenience of the staff, or as a form of punishment. During the onsite review, a member of the Monitoring Team directly observed approximately 22 percent of the 105 individuals prescribed psychotropic medication. The identifying information for these individuals is listed above in the section entitled: "Observations of." These observations did not identify any individuals who appeared to be grossly over-medicated/sedated with psychotropic medication, as might have been expected if these medications were routinely used for the convenience of the staff. The	Noncompliance

#	Provision	Assessment of Status	Compliance
	psychotropic medications shall not be used as punishment.	individuals were all quickly recognized and greeted by the Psychiatric Nurse, who accompanied a member of the Monitoring Team. She was also knowledgeable about the individuals' history and any side effects they may have experienced. The presence of an appropriate psychiatric diagnosis that would warrant the use of psychotropic medication is discussed with regard to Section J.13, and this was a requirement that the Facility had consistently met in previous reviews as discussed with regard to Sections J.2 and J.6 of the Settlement Agreement. In addition, the review of the spreadsheet listing all individuals prescribed psychotropic medications indicated that each of these individuals had a psychiatric diagnosis of record. Fourteen of the 15 (93%) applicable records reviewed included an active Positive Behavior Support Plan (PBSP). The exceptions were Individual #78 and Individual #295. The Behavioral Health Services section for Individual #78 contained a Behavioral Assessment and the ISP, dated 11/22/13, stated that the development of a PBSP was "pending." The record of Individual #295 contained a Psychological Assessment from 2011, which indicated that a PBSP was being developed. In addition, the documentation from the 1/10/14 ISP made reference to an active PBSP, but this was not present in the documentation available for review. For the sixteenth individual in the sample, the Behavioral Health Services section for Individual #343 contained a Psychiatric Support Plan, which appeared to be appropriate for this individual, given the nature of the individual's psychiatric disorder and the influence of that disorder on the individual's behavior. The quality of the PBSPs is discussed in detail with regard to Section K.9. The Monitoring Team's previous reports had noted a significant concern related to behaviors identified as the "target behaviors" of the psychotropic medication also being identified in the Functional Analysis and related PBSP as being present on a behavioral basis and/or related to environmental factors. This observation suggested that for these individuals, the prescribed psychotropic medication could have been utilized to suppress behaviors that were not directly derived from a psychiatric diagnosis, which would not be consistent with the terms of this provision of the Settlement Agreement. In other words, they were potentially being used in the absence of adequate behavioral treatments or interventions. At the time of the Monitoring Team's previous review, the Psychiatry Department, working in conjunction with the Behavioral Health Services Department, had effectively addressed this problem through the development of collaborative, systemic methods. The current review found that these collaborative methods had been effectively continued and maintained. These methods are summarized with regard to Section J.8, Section J.9, and Section J.13.	

#	Provision	Assessment of Status	Compliance
		The use of chemical restraint could be construed as punishment, because it frequently involved the intramuscular (IM) injection of a psychotropic medication against an individual's will. Thus, the description of the circumstances surrounding the involuntary administration of intramuscular antipsychotic and/or anxiolytic medication was extremely important in differentiating between the necessary utilization of these interventions to prevent physical harm to the individual and/or others, as opposed to being used to punish an individual for aggressive behavior, or for the convenience of staff in responding to a difficult situation. In order to further assess the circumstances surrounding the use of chemical restraint at CCSSLC, the related documentation was reviewed for the most recent five episodes of chemical restraint, as based on the material provided by the Behavioral Health Services Department, in response to an onsite request.	

INDIVIDUAL	DATE	TIME	MEDICATION
Individual #253	3/10/14	4:04 p.m.	Zyprexa 25 milligrams (mg) IM
Individual #40 (A)	3/1/14	6:45 p.m.	Zyprexa 10mg IM
Individual #50	2/23/14	10:09 a.m.	Ativan 2mg IM Benadryl 25mg IM Haldol 5mg IM
Individual #40 (B)	12/10/13	7:32 p.m.	Zyprexa 10mg IM
Individual #237	12/6/13	1:25 p.m.	Zydis 10mg PO

The individual restraint data was reviewed for the presence and quality of the five components of documentation the Facility utilized to record the events preceding, during, and following the administration of chemical restraint. These sections and the results of this review were as follows:

- The information contained in the section of the form following the prompt: "Description of behaviors prior to restraint" was reviewed. This section of the documentation had been completed for all five of these individuals. However, the documentation contained in all of these records only described the overt behavior that necessitated the restraint, and did not discuss the events that precipitated this behavior for three of the episodes of restraint: Individual #40 (A), Individual #40 (B), and Individual #5. However, the face-to-face debriefing section of the record provided an adequate description of the events. The documentation for Individual #237 and Individual #253 was adequate in the initial section of the record. Thus, the initial prompt was responded to appropriately for only 40 percent, but the totality of the description was adequate for all (100%).

#	Provision	Assessment of Status	Compliance
		▪ The section that followed the prompt to describe: "Interventions attempted to avoid restraint" was completed for all five (100%) of these individuals. Specifically, there was information that described the attempts to de-escalate the situation. ▪ The physiological post-restraint monitoring portion of the documentation was adequately completed for one episode [i.e., Individual #40 (A)] (20%) of the five in this sample. This section of the documentation for the episodes of chemical restraint for Individual #253 and Individual #40 (B) did not contain monitoring data. The data related to Individual #5 and Individual #237 contained data related to vital sign monitoring, but did not have adequate documentation regarding the mental status. ▪ The face-to-face post-restraint debriefing was also present and completed for all (100%) of these individuals. As noted above, this documentation provided an overview of both the context for the restraint, as well as the evolution of the restraint episode. ▪ The Chemical Restraint Clinical Review Form, which contained sections for the Pharmacy and Psychiatrist to comment on the appropriateness of the chemical restraint and to provide any information that might be used to prevent further episodes, was completed for four of these five (80%) episodes of restraint in a timely manner, and contained adequate information. The exception was Individual #237 for whom there was no Pharmacy review in the documents. The AVATAR computer-generated forms contained only the following three options for the Psychiatrist: *<u>Psychiatrist Review</u>:* *Documentation shows medication used in a clinically justified manner?* *If no, Explain:* *Potential medication-related risks?* *If yes, Explain:* *Actions/Recommendations:* The corresponding yes/no answers for the Pharmacist were: *<u>Pharmacist Review</u>:* *Documentation shows medication used in a clinically justified manner?* *If no, Explain:*	

#	Provision	Assessment of Status	Compliance
		Potential medication-related risks? *If yes, Explain:* *Actions/Recommendations:* However, there were spaces on the form for free-text comments, which generally contained comments concerning the potential risks of the medication used. The Psychiatrist's summary also contained an overview of the circumstances related to the context for the incident being reviewed. These included comments that would be useful to the team as they reviewed the incident and attempted to define strategies that would be useful in preventing future incidents. Thus, the essential elements of the documentation needed to verify appropriate utilization of the involuntary administration of intramuscular medications were adequately and fully completed for none of the five (0%) individuals in this sample. However, this finding was primarily due to the absence of a complete record of the vital signs and mental status observation following the administration of the chemical restraint. As detailed above, the CCSSLC had made progress with regard to the differentiation of psychiatric symptoms and behaviors present on a behavioral basis or in relation to environmental factors. Progress also had been made in ensuring individuals had accurate psychiatric diagnoses that justified the use of psychotropic medication. The rating of noncompliance was based on the finding that the chemical restraint documentation was deficient, and without this it was not possible to conclude that chemical restraint was not being inappropriately used for punishment or for the convenience of staff. In addition, a PBSP could not be located in the record of two of the individuals who were prescribed psychotropic medication. Although, no instances were found to indicate that chemical restraint was definitively used for punishment, there was insufficient information to allow the Facility's staff, or external reviewers to determine that it was not used as punishment or for the convenience of staff.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for	At the time of the Monitoring Team's previous reviews, a new initiative related to this provision of the Settlement Agreement had been developed and implemented. It involved the establishment of an interdisciplinary process to ensure the appropriateness and safety of medications prescribed for sedation prior to medical and dental appointments. This process included direct input from the Psychiatrist, the Psychiatric Nurse, the Unit Nurse, the Primary Care Practitioner (PCP), the Behavioral Health Services Specialist, the Clinical Pharmacist, and the Facility Dentist. These reviews were scheduled to occur on an annual basis for each individual at the beginning of the Psychiatric Clinics, because, with the exception of the Clinical Pharmacist and the Dentist,	Noncompliance

#	Provision	Assessment of Status	Compliance
	pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	all of the disciplines identified above routinely participated in these meetings. The scheduling of the reviews at the beginning of these meetings allowed the Pharmacist and the Dentist to participate in an efficient manner. The spreadsheet tracking the occurrence of these meetings indicated they had been completed for the current year for all (100%) of the individuals who required these interventions. Specific concerns related to the quality of the current Desensitization Plans and other strategies to reduce the need for pre-treatment sedation are discussed with regard to Section C.4 of the Settlement Agreement. At the time of the Monitoring Team's prior review, the Facility had developed a methodology for determining who would likely benefit from a Desensitization Plan to reduce the need for pre-treatment sedation. The Facility's plan involved identifying individuals whom they believed were not candidates for a Desensitization Plan, because they had neurological conditions, such as Cerebral Palsy, and required a benzodiazepine medication prior to a dental visit, primarily for the muscle relaxant properties. The other group, which the decision-tree screened out, consisted of individuals who were thought to have an innate, organically driven, motor restlessness that would make them poor candidates for a Desensitization Plan. The current spreadsheet, dated 2/27/14, entitled: "Psychology Master Desensitization Need List," contained alphabetical listings of individuals, according to sub-categories of the individuals who resided at the Facility. The spreadsheet included their residence and multiple columns that were specific to each of the sub-groups of individuals. ▪ The first group listed 89 individuals and functioned as a working list to help track the progress of these individuals in meeting the goals of their active Desensitization Plans. This data indicated that currently, only 11 Desensitization Plan had been implemented. ▪ The second group (N=141) listed those individuals who did not require Desensitization Plans for dental procedures, as they were edentulous or did not require pre-treatment sedation for dental procedures. ▪ The third group (N=17) were either identified as "Not a DS candidate or need to remove." As described above, the primary reasons for an individual being determined to not be a candidate were the presence of factors, such as physiological spasticity, or extreme baseline innate motor hyperactivity. This list also included those individuals who received general anesthesia for dental procedures and, thus, the Facility had determined did not require pre-treatment sedation for dental procedures. Given that general anesthesia is a form of sedation, and in fact, has significant risks involved, it was not at all clear how the Facility had determined that this group of individuals did not need to be included in efforts to reduce to the extent possible the use of pre-treatment sedation.	

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There appeared to be some overlap within these groups. The prior Director of Behavioral Services, who was no longer at the Facility to explain the different dimensions and sub-categories of the spreadsheet, originally constructed the spreadsheet.

The purpose of the Desensitization Plans, or other strategies, was to provide the individual with the necessary skills to successfully participate in dental or medical procedures without receiving sedative medication prior to the appointment, or to reduce the need for such medication to the extent possible. At the time of the prior review, members of the Monitoring Team attended the 10/2/13 meeting of the Pre-treatment Sedation Desensitization Committee. The following professional disciplines attended this meeting: Medicine, Dental, Nursing, Psychiatry, Behavioral Health Services, Unit Administrators, and the QIDPs. The focus of the meeting was on those individuals who were scheduled to have dental and/or medical procedures in the month of October, in order to proactively develop strategies that would minimize the need for pre-treatment sedation to the extent possible. Similar meetings had been held on 8/13/13 and 7/3/13. An inquiry about the current status of this meeting indicated that it had not met for several months, and it appeared that it had been discontinued following the departure of the former Director of Behavioral Health Services. It was not clear at the time of the Monitoring Team's current review if meetings of this group were going to be resumed.

The Dental Services Department maintained data on the frequency with which intravenous (IV) sedation and pre-treatment oral sedation were required to accomplish successful dental appointments. At the time of the Monitoring Team's prior reviews, this data indicated that approximately 90 percent of the total monthly dental appointments were accomplished without either pre-treatment sedation or IV anesthesia. During the onsite meeting with the Facility Dentist and the Dental Assistant, they noted that these percentages continued to be approximately within the same range.

The following table provides the data for the use of oral sedation, and IV sedation/general anesthesia for individuals who were seen in the Dental Clinic from 8/1/13 through 2/28/14 as well as those who required no such intervention.
<table>
<tr><th>Dates</th><th>Number Of Appointments</th><th>Number (%) Pre-Treatment Oral Sedation</th><th>Number (%) IV Sedation/ General Anesthesia</th><th>Number (%) Requiring No Sedation</th></tr>
<tr><td>8/13</td><td>121</td><td>1 (0.8%)</td><td>3 (2%)</td><td>117 (97%)</td></tr>
<tr><td>9/13</td><td>81</td><td>2 (2%)</td><td>8 (10%)</td><td>71 (88%)</td></tr>
<tr><td>10/13</td><td>131</td><td>1 (0.7%)</td><td>5 (4%)</td><td>125 (95%)</td></tr>
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#	Provision	Assessment of Status	Compliance

11/13	98	1 (1%)	5 (5)%	92 (94%)
12/13	80	1 (1%)	7 (9%)	72 (90%)
1/14	126	0 (0%)	8 (6%)	118 (94%)
2/14	117	1 (0.9%)	2 (2%)	114 (97%)

It should be noted that these frequencies are per appointment, and some individuals did not require sedation for routine appointments, but might require medication for more invasive procedures, such as extractions or extensive cleanings.

The review of the Facility orders for pre-treatment sedation for dental procedures from 8/1/13 through 1/31/14 confirmed that during that time period the orders were primarily for the following medications: Ativan (a benzodiazepine), in a range from one mg to three mg; Atarax (an antihistamine with sedative properties), in a range from 25 mg to 50 mg; or Halcion (Triazolam), in a range from one point five mg to one point seven five mg. The Director of Dental Services indicated that if standard, conservative dosages of sedative medications were not effective, the Psychiatry staff and/or the Pharmacy would be consulted for additional recommendations and, as noted above, the Facility had developed a procedure for the multidisciplinary review of the individuals' pre-treatment sedation in the context of the Quarterly Psychiatric Reviews.

The monitoring for the physiological effects of the oral pre-treatment sedation was initiated in the residences, because the medication itself was administered at those locations, 60 to 90 minutes prior to the appointment in the Dental Clinic. Thus, the pre-administration monitoring of the individual's physiological status was performed at the residence and then transitioned to the Dental Clinic at the time of the appointment. After the work in the Dental Clinic was completed, and when the Dental staff felt it was appropriate to release them, the individual returned to the residence. The IV anesthesia monitoring was very detailed. The Consultant who actually administered the anesthesia also performed the monitoring. The topic of the physiological monitoring related to the use of pre-treatment sedation for dental appointments, and for the use of IV anesthesia, is discussed in more detail with regard to Section Q.

As noted above, the Facility had devoted a great deal of attention to determine which individuals required plans to minimize the use of pre-treatment sedation, and monitoring the use of pre-treatment sedation for dental procedures. However, the documentation that detailed the utilization of pre-treatment sedation from 8/1/13 through 1/31/14, revealed that during this timeframe, there were 81 unique instances of individuals receiving pre-treatment sedation for medical procedures, as compared to five dental procedures. This finding is similar to that described in the Monitoring Team's prior report, which indicated that, although the precise ratio varied over time, the

#	Provision	Assessment of Status	Compliance
		number of administrations of medical pre-treatment sedation always greatly exceeded the corresponding frequency for dental procedures. The majority of the orders for medical procedures were for Ativan, in a range of one point five mg to three mg; and/or Atarax, in a range of 25 mg to 50 mg; Xanax, in a range of one mg to two mg; and Halcion one point five mg to one point seven five mg. Overall, the medications utilized appeared to be appropriate and were prescribed in moderate dosages. The Behavioral Health Services Department had begun to develop Desensitization Plans for medical procedures, but this process was not as advanced as the corresponding initiative for dental procedures. CCSSLC had an effective process in place for coordinating pre-treatment sedation for dental procedures with other professional disciplines, including Psychiatry, Pharmacy, Medicine, and Nursing. However, there did not appear to be a corresponding system for the development of pre-treatment sedation for medical procedures, and it would be useful to extend this process to include pre-treatment sedation for medical procedures. At the 10/13 meeting of the Pre-treatment Sedation Committee, there was a multidisciplinary discussion of everyone who was known to have a medical appointment for which they might require such sedation in the coming weeks. These were very detailed discussions that included both interpersonal interventions as well as pharmacological considerations. However, as noted above, this meeting had not occurred in several months and it was not clear with what regularity it would be maintained going forward. The finding of noncompliance for this provision was based on the observation that fully effective, operational Desensitization Plans to reduce the need for pre-treatment sedation for medical and/or dental procedures had not yet been completely developed or implemented, nor was a system in place for coordinating the pre-treatment sedation plans for medical services. In addition, in their efforts to reduce the use of sedation to the extent possible, the Facility will need to include individuals that require general anesthesia for appointments that typically would not require such an intervention in the general population.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services	The Monitoring Team's previous reviews of psychiatric services at CCSSLC indicated that two full-time Psychiatrists (or the equivalent amount of Consulting Psychiatrists) would be required to adequately evaluate and provide psychiatric services to the individuals residing at the Facility, because many of these individuals presented with complex psychiatric disorders. The current utilization rates of multiple psychotropic agents for numerous individuals would suggest that this was a reasonable estimate. At the time of the Monitoring Team's prior reviews, the professional support staff of the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	necessary for implementation of this section of the Agreement.	Psychiatry Department indicated the above determination was supported by an empirical analysis of the time required to fully meet all of the provisions of the Settlement Agreement, including participation in the ISP process. However, these opinions were initially not based on an empirical time allocation analysis, but rather were primarily subjective in nature. Accordingly, it was recommended that such an analysis be performed, and the Facility was able to produce written documentation that specified the calculations and assumptions that contributed to their findings. This documentation indicated that CCSSLC had taken into account the time required to administer direct clinical services to the individuals prescribed psychotropic medication, attend the ISP meetings, and complete the CPEs on an annual basis. It concluded that two full-time Psychiatrists would be adequate. These determinations also took into account the continued involvement of the Consulting Psychiatrist, as well the assistance provided by the four members of the Psychiatry support team. During the Monitoring Team's previous review, the Facility was relying on one part-time Consulting Psychiatrist to provide day-to-day psychiatric care to individuals' prescribed psychotropic medication. At that time, his weekly allotment of time had been decreased from 12 to eight hours (two four-hour blocks per week). However, in 11/13, this was increased back to 12 hours per week. This allotment of time equated to 30 percent of one FTE Psychiatrist. The Consulting Psychiatrist was Board Certified in Adult Psychiatry. An additional locum tenens Psychiatrist was working onsite, on a 75 percent FTE basis. His time was devoted to completing the CPEs for individuals prescribed psychotropic medication. In addition, Dr. Krishna continued as the full-time Chief of Psychiatry. Besides her administrative responsibilities, the Chief of Psychiatry also completed two to three CPEs per week. At the time of the Monitoring Team's previous review, CCSSLC was found to be in noncompliance for this provision of the Settlement Agreement, because the total number of FTE Psychiatrists was 1.2 FTE, and the Facility's analysis of the Psychiatrists' time allocation indicated that two FTEs were necessary. During the course of that review, the Psychiatry Department presented time allocation data that illustrated how the required functions of the Psychiatry Department were distributed between the full-time Psychiatrist, the Consulting Psychiatrist, the two full-time Psychiatric Nurses, and the two full-time Psychiatric Assistants. The analysis of the time distribution took into account the requirements of the Settlement Agreement. The above analysis was put forth in a detailed, three-page document, which appeared to be mathematically and clinically reasonable. Despite the compelling nature of the	

#	Provision	Assessment of Status	Compliance
		information the Psychiatry Department produced at that time, the language of this provision of the Settlement Agreement specifically states that the professionals who provide the clinical services are required to be "Psychiatrists" who have experience with this population. Thus, it was not possible to find the Facility in substantial compliance with this provision at that time. As noted above, the Facility currently employs one full-time Psychiatrist, a part-time Consulting Psychiatrist who works 12 hours per week (.3 FTE), and a locum tenens Psychiatrist who was onsite 30 hours per week (.75 FTE). This equated to slightly over two FTEs, which, in addition to the two Psychiatric Nurses and the two Psychiatric Assistants, was sufficient to provide the necessary level of psychiatric treatment necessary. The Chief of Psychiatry also indicated that the Facility still had a full-time Psychiatrist block, and there were two viable candidates for that position, one of which was likely to be selected in the near future. Accordingly, the Facility was found to be in substantial compliance with this provision.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for at least three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for at least three consecutive reviews. The substantial compliance finding from the last review stands. Of note, the Facility had modified their policy of repeating the Reiss Screen for all individuals not prescribed psychotropic medication. Specifically, they had replaced the process of repeating the Reiss Screen each year with a system that involved obtaining a Reiss Screen within 30 days of admission for an individual not prescribed psychotropic medication for a psychiatric diagnosis and, as clinically indicated and recommended by the IDT for a change of life status, emerging behavioral symptoms, or in conjunction with Psychiatric Consultations performed on individuals who were not prescribed psychotropic mediation. This change in the Psychiatry Department's protocol was started in 1/14. As noted above, the finding of substantial compliance was continued from the prior	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	review. However, the Facility must develop a method for identifying individuals who have had a change in their psychological/mental status, and then indicate that these individuals have had a thorough evaluation, including a Reiss Evaluation in order for compliance to be maintained during the next review.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The collaboration between the Departments of Psychiatry and Behavioral Health Services was apparent in the interviews with the Director of Behavioral Health Services, the Consulting Psychiatrist, the Chief Psychiatrist, and the other members of the Psychiatry Department. In addition, observations of the Psychiatric Clinics that occurred on 4/2/14 indicated that the Behavioral Health Services Specialist played an important role in both the conduct of the meeting, and the analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. In terms of case formulation, the Monitoring Team's initial reviews revealed a persistent deficit in this collaboration. Specifically, there was the co-identification of the same behaviors as being both a "target behavior" of the prescribed psychotropic medication, and also being present on a learned or behavioral basis in the Functional Assessment and the PBSP. As indicated in Monitoring Team's previous reports, it is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be delineated clearly. The Psychiatry Department, working in conjunction with the Behavioral Health Services Department, had developed a system, which was responsive to recommendations in the Monitoring Team's previous reports, to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. These observations are also relevant to Section J.2 and Section J.9 of the Settlement Agreement. In summary, these innovations clarified the symptoms of the psychiatric disorder for which the psychotropic medication was prescribed. The Behavioral Health Services Department also had developed a section in its assessment entitled: "Psychiatric Information," which described how the psychiatric disorder would affect the behavioral presentation for those individuals for whom this was relevant. This coordinated, complementary documentation was evidence of collaboration between the Psychiatry and Behavioral Health Services Departments with regard to combined case formulation. The impact of the psychiatric disorder on the individual's problematic behavior also appeared throughout the Behavioral Health Services documentation where it was relevant. The integration of the behavioral data into the Psychiatry Clinic documentation is also discussed with regard to Section J.13. The Psychiatry Department's utilization of	Noncompliance

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		objective measurement tools is reviewed in relation to Section J.13. The primary disciplines that attended the Monthly and Quarterly Psychiatric Clinics were Nursing, Psychiatry, Behavioral Health Services, Medicine, a direct support professional, and a QIDP. However, disciplines such as Occupational Therapy and Physical Therapy were not able to attend the individual Psychiatry Clinic reviews due to time constraints. These disciplines often did attend the individual ISP meetings. The ISP meeting documentation was reviewed for the 16 individuals in this sample. This review indicated that a member of the Psychiatry Department attended the annual ISP meeting for all (100%) of the 16 individuals in the sample. At the time of the Monitoring Team's previous (9/13) review, the Psychiatry Department had attended the ISP of 14 of the 16 (88%) individuals whose records were reviewed in conjunction with that report. The Department also intended to prepare the documentation representing the individual's psychiatric treatment, which would be reviewed during the ISP Preparation Meeting, and then discussed in the annual ISP meeting. This documentation would be completed in conjunction with the individual's annual Integrated Risk Rating Form (IRRF), which had been modified to contain a joint Behavioral Health section, as well as the Polypharmacy section, for those individuals whose medications met the criteria for polypharmacy. The Behavioral Health section represented a collaborative effort between the Psychiatry and Behavioral Health Services Departments for those individuals both disciplines served. This initiative had resulted in the development of a document entitled: "Psychoactive Medication Treatment Plan," which contained the following 13 major headings: ▪ Demographics/Brief History Statement; ▪ Psychiatric Diagnosis of: Table Axis I, II, III, IV, and V; ▪ Symptoms of Diagnosis; ▪ Target Behaviors Monitored; ▪ Antecedents; ▪ Psychological Assessment; ▪ Combined Behavioral Health Review/Formulation; ▪ Psychoactive Medication; ▪ Monitor for efficacy; ▪ Expected therapeutic timeline; ▪ Risk of Medication; ▪ Risk of Illness; ▪ Non-pharmacologic Treatment; ▪ Risk versus Benefit Discussion; ▪ Past Pharmacotherapy; and ▪ Future Plans.	

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A request for a list of the individual ISP meetings that a member of the Psychiatry Department had attended from 8/1/13 through 4/2/14 showed attendance at the ISP meetings for 64 of the 68 (94%) individuals who were scheduled for an annual ISP in this timeframe and who were prescribed psychotropic medication.

For the sample of 16 individuals, there was sufficient evidence that the Psychiatric Treatment Plan (PTP) was discussed during the ISP meeting for 10 (63%) of the 16 individuals. The evidence referred to consists of a specific notation in the ISP that the PTP was reviewed and discussed during the meeting. The ISP documentation for these individuals also contained relevant information in the IRRF as well as the narrative discussion (i.e., information was not repeated in both places, but relevant information was included in each place), which followed the heading for the PTP. The six individuals for whom adequate documentation could not be found to substantiate a review of the PTP included: Individual #12, Individual #78, Individual #92, Individual #292, Individual #354, and Individual #255. In order to expand the sample of ISP documentation and the related PTP, an additional sample of ten ISPs and the corresponding PTP was requested as follows:

<table>
<tr><th>Name</th><th>ISP Date</th><th>Psychiatric Treatment Plan</th></tr>
<tr><td>Individual #88</td><td>3/25/14</td><td>3/10/14</td></tr>
<tr><td>Individual #321</td><td>3/21/14</td><td>3/12/14</td></tr>
<tr><td>Individual #39</td><td>3/20/14</td><td>3/3/14</td></tr>
<tr><td>Individual #60</td><td>3/19/14</td><td>3/7/14</td></tr>
<tr><td>Individual #275</td><td>3/18/14</td><td>3/3/14</td></tr>
<tr><td>Individual #95</td><td>3/12/14</td><td>3/3/14</td></tr>
<tr><td>Individual #53</td><td>3/11/14</td><td>2/23/14</td></tr>
<tr><td>Individual #7</td><td>3/6/14</td><td>2/28/14</td></tr>
<tr><td>Individual #144</td><td>2/28/14</td><td>2/20/14</td></tr>
<tr><td>Individual #153</td><td>2/18/14</td><td>2/17/14</td></tr>
</table>

It should be noted that a selection criteria for this additional sample was the attendance of a member of the Psychiatry Department at the ISP meeting, so that factor was not specifically scored. In addition, the request for this information also indicated that the Facility should select recent ISPs that reflected what they viewed as their best efforts at complying with the requirements of this provision. All (100%) of the ISPs contained in the records of individuals within the expanded sample contained a reference to the specific information required in this provision. This brought the percentage for the total sample to 20 of the 26 (77%) individuals. However, the reference to this discussion was remarkably similar within each of these ISPs, as indicated by the following example from
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		the 3/25/14 ISP for Individual #88. It is important to note that the individuals' names and specific medication were specified in the original document as well as the other ISPs that were constructed in a similar manner: *<u>Psychiatric Treatment Plan/Psychoactive Medication Treatment Plan</u> – A member of the psychiatry department attended the ISP. Discussed the risk vs. benefit related to the medication of **[names of prescribed medication here],** along with alternative forms of treatment. The behavioral strategies are not fully effective and without psychotropic medications there is a potential for **[first name of Individual here]** to decompensate. The harmful effects of mental illness out weight [sic] the possible harmful effects of psychotropic medications. Medications can help stabilize **[first name of Individual here]**, allowing him to progress further in the behavioral treatment program. Although antipsychotic medications can't cure the illness, they can limit some of the most aggressive symptoms, those [sic] allowing the individual to function outside of the hospital [sic], improve his daily functioning and help make other treatment, such as behavioral interventions, more effective. Medications can help the individual better be able to regulate his mood to the extent of decreasing intensity and frequency of rage reaction. The Psychiatric staff requested that the team agree to the treatment plan as presented and discussed in the IRRF. The IDT discussed each of the risk factors identified on the Risk Guidelines. The discussion included review of assessments/risk-related data, current supports, and baseline information. The need for new supports was analyzed and plans developed as appropriate. An integrated discussion yielded the appropriate rationale for a risk rating of Low, Medium, or High for each risk factor of polypharmacy/side effects of medications and behavioral health. The rating is based on clinical reasoning in combination with the resident's unique circumstances, preferences, strengths, and needs. All actions were designed to promote the individual's optimal safety, health, and quality of life. The Psychotropic Medication Treatment Plan is dated **[date of PMTP here]**. The IDT agreed. Refer to the Psychotropic Medication Treatment Plan submitted to the ISP. Diagnosis of **[diagnosis specific to the Individual here]**.* *The recommendations include:* 1. *Continue with his **[current medications here]**.* 2. *Continue medication monitoring, physical care monitoring, lab and testing monitoring. Also, BSP and other treatments in combination.* 3. *His medications are monitored by the interdisciplinary team and consulting psychiatrist on a regular basis. Medication effects monitoring will occur with DSPs documenting the behavior data. The Behavioral Health Specialist*	

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		collecting and analyzing the behavioral data and generating monthly progress notes. The psychiatrist will review the PBSP and psychology plan data [at] least monthly and the IDT will meet at least quarterly in psychiatric clinic to evaluate treatment efficacy. *4. Community Placement Recommendation – With minimal episodes of target behavior **[list Individual's target behaviors here]** would recommend consideration of less restrictive setting with the following recommendations put in place to be followed up on a regular basis by a psychiatrist for psychiatric medication management, continue with his Positive Behavior Support Plan to work on his targeted behavior, highly structured environment and 24 hour awake staff.* This documentation represented a significant improvement over that found in the Monitoring Team's prior reviews, and included a reference to the topics and items identified in the Settlement Agreement. However, the observation that this information was formatted in almost exactly the same manner in the ISPs reviewed, gives the reader the impression that it represented a template that would simply be filled in with the names and dates relevant to the individual, and would not be individualized. In addition, the template appeared to predetermine that the benefits of the medication outweighed the risks. The point of having the team discuss the PTP is to objectively review each year whether or not this is the case. These criticisms are not meant to imply that this organization of the relevant material should be abandoned, but rather, that it should be augmented with references to the unique discussions that occurred amongst team members during the ISP, including any specific questions that might have been asked of the Psychiatrist, along with the answers to those questions. The discussion should show that the team engaged in a critical discussion of the PTP, and drew its conclusions based on objective data. Thus, the finding of noncompliance was carried forward from the prior review, as the rate of 77 percent in the expanded sample of 26 individual records was not sufficient to warrant a finding of substantial compliance. In addition, the references to the discussion of the PTP that appeared in the ISP documentation for those 20 individuals appeared to be derived from a template. This represented a reasonable way to format the key elements of the discussion, but it was difficult to infer from those statements how comprehensive and detailed the actual discussions were without additional information.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric	As noted above with regard to Section J.8, the integration of psychiatric and psychological behavioral services was evident in the conduct of the Psychiatric Clinics, as well as the documentation found in the sample of 16 records of individuals receiving psychotropic medication. The Monitoring Team's initial reports revealed a significant deficiency in this process related to the degree to which behaviors identified as being	Noncompliance

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	care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	targets of a psychotropic medication also were identified in the Functional Assessment and the PBSP as being present on a learned/behavioral basis and/or as being related to environmental factors. It is entirely feasible that a given behavior could be co-determined by both biological and behavioral factors. However, the dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis suggested that the medications were being used to suppress environmentally-determined behaviors, and/or that the PTPs and the PBSPs were developed through parallel processes that were not fully integrated. The differentiation of the problematic behaviors the individuals presented is directly related to the concluding requirement of this provision, specifically: "the need to minimize the need for psychotropic medication to the degree possible." As long as these deficiencies existed, it would increase the risk that the individual could be prescribed unnecessary psychotropic medication. In addition, the individual would not receive the behavioral supports appropriate to address the problem. A review of the documentation from the Departments of Psychiatry and Behavioral Health Services addressing this issue were discussed in previous reports with regard to Section J.2, and are summarized with regard to Section J.8. The Facility's status with regard to "minimizing the need for psychotropic medication to the degree possible" is discussed in detail with regard to Section J.11. In its efforts to address the issues related to the misidentification of behaviors, the Psychiatry Department had modified the format for the Quarterly Psychiatric Reviews so that it would contain more explicit information concerning the linkage between the symptoms of the individual's psychiatric disorder and his/her other monitored target behaviors. These more comprehensive Quarterly Review documents had been in routine use for all of the individuals prescribed psychotropic medication for over two years. The CPEs met the quality standards of the Settlement Agreement and also provided discussions addressing this differentiation. These discussions primarily appeared in the Bio-Psycho-Social-Spiritual Formulations section of the CPEs, and the discussions of the differential psychiatric diagnoses, as well as the Quarterly Review documentation discussed above. In addition, the Behavioral Health Services Department had added a section to their documentation entitled: "Psychiatric Information," which also addressed this issue. The Behavioral Health Services Department also included references to the influence of the individual's psychiatric disorder on their maladaptive behaviors throughout their documentation, as appropriate. Thus, the integration was more comprehensive than just a single summary paragraph. All of these methods are described in more detail with regard to Section J.8. This provision also stipulates this information should be discussed during the ISP	

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		meeting and referenced in the ISP meeting documentation. As noted with regard to Section J.8, a member of the Psychiatry Department had been able to attend the ISP meetings for all of the individuals in the sample of 16 (15% of those prescribed psychiatric medication). In addition, the information in the PMTP and the IRRF had been completed for each of these individuals. The finding of noncompliance for this provision was based on the same rationale as described in the discussion related to Section J.8. Specifically, the documentation found in 20 of the 26 (77%) individual records that comprised the expanded sample of 25 percent of individuals receiving psychotropic medication, contained information that addressed the language of the Settlement Agreement regarding Section J.8, Section J.9, and Section J.10. However, this documentation was remarkably similar in all of these records, resembling a template. This information should be augmented with a summary of the actual discussion that took place during the ISP meeting, as well as questions directed to the Psychiatrist, along with the corresponding answers. It should show that teams have critically reviewed the PTP as well as the non-pharmacological treatment(s), and recommended changes, as appropriate.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	This provision of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications for a specific individual. The Monitoring Team's initial reports indicated that these discussions primarily appeared in the HRC section of the record, as well as the PBSP, and usually concluded that the benefits of the proposed medications outweighed the risks presented by their side effects. The descriptions of the benefits were formulaic in nature, and the benefits were uniformly described as a reduction in the behaviors identified as the targets of the psychotropic medication. The Facility had responded to the recommendations contained in the Monitoring Team's initial reports. Specifically, the Facility was providing more information related to the risk-versus-benefit equation for the psychotropic medications in the Quarterly Psychiatric Reviews and the CPEs. As indicated with regard to Section J.8 and Section J.9, the PTP and the IRRF provided specific additional information regarding the risk-versus-benefit considerations. Both the IRRF and the PTP had been expanded to include more detailed information, including information regarding the potential and/or realized side effects, as well as the potential and/or realized therapeutic benefits of the medication, and the rationale for those determinations. The PTP (the contents of which are detailed in relation to Section J.8) also provided specific information concerning less intrusive, non-pharmacological interventions that had either been considered or implemented and found to be ineffective. All of the 16 individuals reviewed, in the sample of 15 percent of individuals prescribed psychotropic medication, contained an updated CPE, Quarterly Review documentation, the IRRF, and PTP, each of which contained information related	Noncompliance

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		to the risk-versus-benefit consideration. In addition, the Facility had developed a tool to be utilized in the review of the psychotropic medications at the HRC meetings. This tool included specific prompts to facilitate the review of the major considerations that both clinicians and the members of the HRC should take into account when assessing the risk-versus-benefit of prescribed medications. The implementation of this instrument had improved the quality of the discussions and the related documentation, as based on the observation of this information over several of the Monitoring Team's reviews. On 4/2/14, a member of the Monitoring Team attended the HRC meeting. The reviews that occurred at this meeting were thorough, detailed and comprehensive. The observations of the deliberations of the HRC meetings during the Monitoring Team's prior onsite reviews were also consistent with these findings. At the time of the Monitoring Team's initial review, it was noted that the thoroughness of these discussions was not always reflected in the documentation subsequently found in the record reviews. The Facility had responded to these recommendations by changing the format of the HRC meeting minutes, so they covered the salient aspects of the discussions in a succinct manner. The finding of noncompliance for this provision was due to the same deficits in the ISP documentation, as referenced with regard to Sections J.8 and J.9, in that the material contained in the ISP was too brief to draw any definitive conclusions about the extent of the discussions that occurred in those meetings, and did not show that teams had conducted a critical review of the psychiatric and other treatment options.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is	CCSSLC had continued its policy of reviewing individuals whose psychotropic medication regimens met the criteria for polypharmacy on a monthly basis. The review of the "Monthly Psychiatry Polypharmacy Reduction Meeting Notes" for the prior six months indicated that the Chief of Psychiatry, Consulting Psychiatrist, an Attending Physician, a member of the Behavioral Health Services staff, a representative from the Quality Assurance Department (variable), a representative from the Pharmacy, a Psychiatric Nurse, and the Psychiatry Assistant regularly attended these meetings. The meeting notes indicated that the group engaged in detailed, case-centered discussions of individuals whose medication regimens met the criteria for polypharmacy. This discussion focused on the feasibility and current status of the attempts to reduce polypharmacy for specific individuals. Documentation from the 4/1/14 meeting provided a summary of the Facility's progress toward minimizing polypharmacy as of 4/1/14. As per recommendations made in the Monitoring Team's previous reports, the Facility tracked the status of the individuals	Substantial Compliance

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<tr><td></td><td>clinically justified, and that medications that are not clinically justified are eliminated.</td><td>who were admitted from the community within the last year separately. At the time of the Monitoring Team's onsite review, this list included only two individuals, as compared to six at the time of the last review. The data for the remaining 103 individuals indicated that 11 (11%) of these individuals were receiving two or more medications from the same class, and 37 (36%) individuals were receiving three or more medications, regardless of class. Of these, ten individuals were in both the three-or-more and the intra-class categories. Thus, the total number of individuals who met the criteria for polypharmacy was 38 (37%).

Historical data from several years ago was not available for comparison. However, monthly comparative data was available from October 2010. It should be noted that individuals who were prescribed three or more psychotropic medications and also met the criteria for intra-class polypharmacy (as two of these medications are from the same class) were only counted once. Tabular representation of that data is as follows:

<table>
<tr><th>Definitions of Polypharmacy</th><th>October 2010</th><th>September 2013</th><th>April 2014</th></tr>
<tr><td>Number of individuals receiving two or more medications from the same class</td><td>37</td><td>14</td><td>11</td></tr>
<tr><td>Number of individuals receiving three or more medications regardless of class or indication</td><td>81</td><td>45</td><td>37</td></tr>
<tr><td>Total number of individuals on polypharmacy</td><td>81</td><td>46</td><td>38</td></tr>
<tr><td>Total number of individuals receiving psychotropic medication</td><td>145</td><td>106*</td><td>103*</td></tr>
<tr><td>Percentage patient population receiving psychotropic medication whose medications met the criteria for polypharmacy</td><td>56%</td><td>43%</td><td>37%</td></tr>
</table>
*These numbers did not include the individuals who had been admitted in the previous 12 months.

This provision of the Settlement Agreement also states that it is necessary "to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated." Thus, this provision also relates to the documentation</td><td></td></tr>
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		that prescribed medications can be empirically demonstrated to be effective. The discussions with the Psychiatry Department regarding the individuals whose psychotropic medication regimens continued to meet the criteria for polypharmacy indicated that the Psychiatric Team believed many of these medications were essential for the individuals' stability. This belief also was reflected in the minutes of the monthly Psychiatric Polypharmacy Reduction Committee meetings. Subsequent to the Monitoring Team's previous reviews, the Facility had implemented the recommendations to develop a categorical approach in order to clinically justify and/or systematically pursue reductions in an individual's medications. The categories utilized included the following: individuals who were admitted within the last year and were prescribed psychotropic medication (N=2); those who were in the "Active" category (N=3); and those who were in the "Stable" category (N=35). The "Active" category referred to those individuals who were so clinically complex that they still required active review on a monthly basis. The "Stable" category represented those individuals who were considered to be clinically stable at the time of the review, and the Psychiatry Department believed their current medications could be justified by the historical information and/or their clinical fragility, in that their status was such that a change in the dosage of medication to establish empirical justification would be considered too risky. As noted above, the Facility tracked, as a separate category, those individuals admitted from the community and prescribed multiple psychotropic medications. At the time of the Monitoring Team's onsite review, that group included only two individuals. Individuals continue to be admitted from the community on multiple psychotropic medications, which the Facility gradually begins to decrease after the individual has had time to adjust to their new environment. During the 4/1/14 Polypharmacy Committee Meeting, there was an active discussion of both of these individuals who, at that time, had tapering schedules for one of their medications, which (if successful) would lead to the discontinuation of that medication. The analysis of the categories above indicated that the Facility's overall rate of polypharmacy was 37 percent (38 of 103), excluding those individuals who had been admitted to the Facility within the last year. CCSSLC placed three of these individuals (3 percent of the total prescribed psychotropic medication) in the "Active" group, who were not considered to be clinically stable, and whose medications required frequent adjustments; and the remaining 35 (34%) represented those individuals for whom they felt their multiple psychotropic medications could be "justified," according to the rationale described above. The Polypharmacy Committee previously reviewed five individuals in-depth every month. This methodology had been implemented in September 2012. Beginning in the	

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		April-May 2013 time period, CCSSLC embarked on a new initiative, which involved an intensive review of each individual who met the criteria for polypharmacy. The goal was to determine if there was sufficient clinical and historical data to make a decision as to whether their psychotropic medications could be clinically justified, or if they continued to require ongoing frequent adjustments in their psychotropic medications. This process involved an intensive review of the historical records, as well as research into the archival records, as normally only one to two years of historical data was carried forward in the individual's active record. In order to provide this longer historical perspective, the Psychiatric Nurses compiled information concerning several years of historical data for the individuals the Facility had placed in the "Stable" category. The result of this labor-intensive endeavor was a spreadsheet that initially contained 62 pages of detailed historical information. The current 4/1/14 updated version was 55 pages in length. It described the reasons for past changes in an individual's psychotropic medication, as well as the rationale for the current medications prescribed. Following the prior onsite review, an intensive review of the documentation that had been presented during the review was conducted. This review found that the information was sufficient to substantiate the efficacy of these medications for all except three individuals the Facility had placed in the "Stable" category. The three individuals for whom the final review differed from that of the Facility's initial determination (as of the 9/13 review) were as follows: Individual #372, Individual #218, and Individual #158. The clinical complexity of these individuals was not in question. However, there had been so many changes in their medication that it was difficult to form definitive conclusions concerning efficacy, and it appeared that they would be more appropriately placed in the "Active" category. At the time of the current onsite review, the Psychiatry Team provided additional follow-up information on these three individuals, which was obtained after they reviewed the Monitoring Team's prior report. Specifically, for Individual #372, the medication was challenged and resulted in deterioration in behavior, which led to restoration of the dosage, followed by behavioral improvement. This intervention justified the utility of the medication. Individual #158 subsequently also had a psychiatric decompensation following a change in dosage, which provided the justification for the medication. The follow-up information for Individual #218 indicated that the Psychiatrist, working in conjunction with the other team members, concluded that the behaviors related to his Bipolar Disorder represented a potential danger to others and, thus, justified the continuation of the current medications, to maintain relative stability. Since the Monitoring Team's last review, nine individuals had been moved from the "Active" to "Stable" Polypharmacy list. A number of individuals also were removed from the list, due to discharges or reductions in medications. Those who were added to the "Stable" list were as follows:	

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		INDIVIDUALS MOVED FROM ACTIVE TO STABLE LIST IN PAST SIX MONTHS (9/1/13 to 4/1/14) 1. Individual #119: Moved to Stable list on 9/20/13; 2. Individual #144: Moved to Stable list on 9/20/13; 3. Individual #336: Moved to Stable list on 9/20/13; 4. Individual #118: Moved to Stable list on 10/1/13; 5. Individual #372: Stable to Active and back to Stable on 12/31/13; 6. Individual #146: Moved to Stable list on 12/31/13; 7. Individual #335: Moved to Stable list on 12/31/13; 8. Individual #147: Moved from Active to Stable list on 2/28/14; and 9. Individual #172: Moved from Active to Stable list on 2/28/14. During the onsite review, a member of the Monitoring Team reviewed the written rationale for these changes, and also discussed them with the Psychiatric Nurse. The review of this material and the related discussions indicated that there was an adequate rationale for these classifications. The prior review also found that two individuals were incorrectly classified as receiving psychotropic medication regimens that met the criteria for polypharmacy. These individuals were (medications prescribed): Individual #174 (Seroquel, Aricept, and Namenda); and Individual #326 (Fanapt, Aricept, and Trazodone). The documentation for these individuals clearly indicated that the Aricept and/or Namenda were being prescribed for a cognitive decline related to dementia, which is an approved use of these medications, as a medical/neurological intervention, rather than as a treatment for a psychiatric disorder. At the time of the current review, the Psychiatric Team indicated that medications used for a cognitive decline related to dementia were no longer classified as psychotropic in nature. The review of the 55 pages assembled for the current 35 individuals in the Stable Polypharmacy Group was found to provide sufficient information to support the Facility's classification. The Facility was found to remain in substantial compliance with this provision, because this is an acceptable rate of polypharmacy, given the clinical complexity of the individuals who resided at the Facility and the justifications for its continued use for the great majority of individuals for whom it was prescribed.	
J12	Within six months of the Effective	The parties agreed the Monitoring Team would not monitor this provision, because the	Substantial

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	Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	Facility was in substantial compliance for at least three consecutive reviews. The substantial compliance finding from the last review stands.	Compliance
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	This provision of the Settlement Agreement addresses processes that are essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." The review of the records of a sample of 16 individuals (15 percent of the total receiving psychotropic medication) indicated that a description of the specific symptoms supporting the psychiatric diagnosis of record could be identified for all (100%) of the individuals. The narrative of previous reports related to Section J.2 also contained a detailed review of the updated process and documentation related to establishing a psychiatric diagnosis at CCSSLC. The current CPEs contained sections that discussed the diagnosis, as did the Quarterly Psychiatric Reviews. Each individual record also contained a "DSM-IV-TR Diagnostic Checklist," which verified that the diagnosis of record for that individual met the specific diagnostic criteria for each Axis I and/or Axis II diagnoses. These Checklists had been developed and implemented at the time of the Monitoring Team's prior review. In addition, in the Monitoring Team's previous reports, a discussion was included regarding the utility of developing a method that would more specifically track the symptoms of the individual psychiatric disorder, as well as the identified "target behavior." The Psychiatry team had initially responded to this by developing a psychiatric symptoms tracking scale. It defined 21 symptoms that related to the Major Axis I psychiatric diagnoses. This instrument had evolved into a more concise scale that consisted of the following eight categories of symptoms: 1. Mood disturbance (Depression/Mania/Hypomania); 2. Psychosis (Hallucinations/Delusions/Paranoia); 3. Obsessive Compulsive Disorder (OCD) symptoms;	Substantial Compliance

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		4. Sleep disturbances (Insomnia/Hypersomnia); 5. Attention Deficit Hyperactivity Disorder (ADHD) symptoms (Inattention/Hyperactivity/Impulsive); 6. Impulsive/Aggression to self or others Self-injurious Behavior (SIB)/Pica, etc.; 7. Suicidal/homicidal ideations; and 8. Anxiety. This form was completed by the members of the IDT in the Psychiatric Clinic on a quarterly basis, and was primarily used for tracking symptom severity over time. On 9/13/13, the QA/QI Committee approved the process. These discussions occurred in the Quarterly Psychiatry Clinics and, thus, included the IDT members that routinely attended those meetings. The Quarterly Review documentation included 18 specific domains of clinically relevant information, which collectively covered the broad categories of the individuals' psychiatric diagnosis and current status. The subsections of this document included the prescribed psychiatric medications, as well as side effect and behavioral considerations, the medical diagnosis in addition to the status of any neurological involvement, and recommendations for future interventions and monitoring. This information was presented in a logical format that made it relatively easy to absorb the content, despite the amount of information presented. As discussed with regard to Section J.8 and Section J.9, observation of the 4/2/14 Psychiatric Clinics indicated there was an interdisciplinary discussion of the clinical issues involving the individual that informed decisions regarding the utilization of psychotropic medications. Beginning in September 2013, the Psychiatry Department had also added a section to the Quarterly Review documentation related to the risk-versus-benefit considerations. In addition, beginning in April 2013, the PTP described in relation to Section J.8, was finalized and implemented for all of the individuals prescribed psychotropic medication. This provision of the Settlement Agreement also addresses the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatments' efficacy." In addition, a requirement of this provision of the Settlement Agreement relates to the Facility's ability to develop and maintain data collection methods sufficient to determine if the medications being utilized were effective. These "symptoms or behavioral characteristics" were now effectively identified through the methods described above. In addition, the relationship between the psychiatric disorder and the behaviors addressed by Behavioral Health Services were clarified in the Bio-Psycho-Social-Spiritual formulation of the CPE, the Quarterly Psychiatric Review Notes, and the Psychiatric Information section of the PBSP. The	

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		symptoms of the psychiatric disorder for which the psychotropic medication was prescribed also were monitored to assess the efficacy of the medication through the information brought to the clinics and reviewed by the clinic teams. As indicated with regard to Section J.11, the Psychiatry Department also had developed a major initiative to compile the psychiatric documentation necessary to document the efficacy of multiple psychotropic medications for those who required polypharmacy to maintain their stability. A requirement of this provision of the Settlement Agreement relates to the Facility's ability to develop and maintain data collection methods that are sufficient to determine if the medications being utilized are effective. The specific language in this provision that addresses this issue is as follows: *"…the psychiatrist shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur…."* As indicated in the comments above and in the narrative discussion related to Section J.11, CCSSLC had developed methods to assess the efficacy of the psychotropic medications, both through the Quarterly Review documentation and the deliberations of the Monthly Polypharmacy Committee Meetings. The Quarterly Psychiatric Review documentation identified the timelines with which the prescribed medication could usually be expected to begin to exert therapeutic effects. Although this information was uniformly present for each medication the individual was prescribed, this was no longer clinically relevant in many cases, because the medications had been prescribed for several months or years. However, this information was important for assessing the efficacy of newly prescribed medications for which these timelines would be important to consider. CCSSLC Psychiatry and Behavioral Health Services' Progress Notes routinely carried forward several months of behavioral data. Recommendations in the Monitoring Team's prior reports indicated that the determination of the efficacy of psychotropic medications would have benefitted from a longer overview of the chronological objective behavioral data. Data that presented the frequency of these behaviors over time in both a tabular and graphic format, including a summary of the contemporaneous medication changes and/or changes in the PBSP would greatly enhance the utility of this information and provide the additional historical data points with which to make comparisons with current frequencies. This additional data would then enable the Psychiatric Treatment Team to ascertain if a specific psychotropic medication could be determined to be	

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		effective from an empirical perspective. The Psychiatry Department responded to these recommendations by undertaking an intensive review of the long-term, longitudinal, pharmacological history for those individuals who met the criteria for polypharmacy. This process, which is described in more detail with regard to Section J.11, involved the Psychiatric Nurses reviewing information from the individual's archival records, which in some instances, dated back several years. This information indicated that for the majority of the individuals who were prescribed multiple psychotropic medications, the use of those medications could be justified. Although the Psychiatry Department had devised a method for monitoring the frequency and intensity of the symptoms of the psychiatric disorder, they were dependent on the individual Behavioral Health Services Specialist to monitor the frequency of these as well as the other monitored behaviors presented in the Psychiatric Clinic notes. In addition, the primary source for all these ratings were the direct support professionals who actually completed the rating forms that were then reviewed by the Behavioral Health Services Specialist. These behaviors would primarily be those that were derived from the symptoms of the psychiatric disorder and/or those determined by both psychiatric and behavioral factors. Direct support professionals collected the actual raw data for these behaviors under the direction of the Behavioral Health Services Specialist assigned to the individual's residence. Concerns with regard to the accuracy and reliability of this data are discussed with regard to Section K.10. The final section of this provision relates to the frequency with which the Psychiatrist reviewed individuals' prescribed psychotropic medication. The current review of a sample of the medical records indicated that Quarterly Reviews were performed as specified in this provision for all of the 16 (100%) individuals, both in terms of timeliness, as well as the quality of the documentation and its responsiveness to each of the requirements. The Facility had maintained the quality of these reviews as discussed in detail in the last report. The documentation that the Psychiatrist had evaluated the individual at the time of the Quarterly Review was contained in the detailed Mental Status section of these documents. As discussed with regard to Section J.8, the Psychiatrist, a Psychiatric Nurse, a Psychiatric Assistant, the PCP, the QIDP, the Residential RN Case Manager, and a direct support professional usually attended the Psychiatric Clinics. The Facility remained in substantial compliance with this provision, as their completion rate for each of the multiple requirements of this provision was 100 percent, based on the review of individual records and related relevant documentation, as described above.	

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J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The review of the Rights/Consents sections of the medical records for the sample of 16 individuals indicated that eight individuals had a Guardian of the Person. Those individuals without a guardian relied on the Facility Director to review the material concerning risk-versus-benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. The review of the individual records indicated that consents for the use of psychotropic medications had been obtained in a timely manner for all of the 16 (100%) individuals in the sample. At the time of the Monitoring Team's prior reviews, CCSSLC had implemented a number of measures to improve the risk-benefit analysis, as well as the quality of the information provided to the guardian or Facility Director regarding the possible side effects of the proposed medication. Specifically, the more generic material referred to in the Monitoring Team's earlier reports had been replaced with material from Micromedex, which is a nationally respected source of pharmacological information. This material was consistent with accepted standards for this type of information and provided both a reasonable description of the potential risks of the medication as well as the potential benefits. In addition, the Facility had implemented an initiative to replace the practice of obtaining consents and HRC approval for all of the individual's psychotropic medication as a package with a process of obtaining consent for each medication as a separate entity. This change in the consent process also was mirrored in the HRC review process, in that the HRC review approval process now addressed each medication as a separate entity. The consent information/documentation for the two individuals reviewed in the 4/2/14 meeting were for Individual #39 (Zyprexa 3/12/14 – Latuda 3/17/14, annual reviews); and Individual #169 (Depakote ER 3/26/14 – Tenex 3/26/14 – Chantix 3/26/14, annual reviews). These were reviewed and found to contain the necessary information in a manner that a guardian could understand. A member of the Monitoring Team also attended this meeting and found the discussion of the risk-versus-benefits of a proposed medication thorough and thoughtful. Each psychotropic medication consent form was renewed on an annual basis. The Facility also had implemented significant changes to the consent process since the Monitoring Team's initial reviews. Rather than having the individual's Behavioral Health Services Specialist obtain the consent from the guardian, the Nurse in the residence would secure the consent. The communication between the nurse and the guardian was primarily written, unless a verbal discussion was requested by the guardian and/or was required to implement the medication on an urgent basis. However, the Psychiatrist and the other members of the Psychiatry Department, including the Psychiatric Nurses and the Psychiatric Assistants, all contributed to the information presented to the person providing consent. The Consulting Psychiatrist did not have any direct, written, or verbal contact with the guardian unless it was requested, or in the event that the guardian attended the Psychiatry Clinics, which was a relatively rare occurrence. The consents	Substantial Compliance

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		supplied by the Facility's Director for those individuals who did not have guardians were via written communication, unless the Facility Director had specific questions for the Psychiatric Team. At the time of the 3/31/14 meeting with the Pharmacy staff, the Director of Pharmacy Services indicated that the Pharmacy had developed a policy of manually verifying that there was a signed consent for a new psychotropic medication before they would dispense the medication. In the event that a medication was begun on an emergent basis, they would dispense a seven-day supply, which could be extended for another seven days, if necessary. However, if the signed consent was not available by the end of the second seven-day period, the medication would no longer be dispensed. During the 4/2/14 interview with the Human Rights Officer, she confirmed that after a medication was approved in the HRC meeting, she delivered a copy of the consent (with all the necessary signatures) to the Pharmacy. She also indicated that beginning in December 2013, electronic copies of the signed consent forms were available in the individual's folder on the shared drive and the original remained in the active record. The status of this provision is, to some extent, dependent on the Facility's ability to fulfill the requirements of Section J.10 regarding the analysis of the risk-versus-benefit considerations related to the use of psychotropic medication. This subject is reviewed in considerable detail in the narrative discussion related to Section J.10, and as noted in that review, the risk-versus-benefit considerations were referenced in multiple documents in the individual's record, but were analyzed in detail in the expanded IRRF in conjunction with the PTP, which were completed for all of the 16 (100%) individual records. The continued finding of substantial compliance for this provision of the Settlement Agreement was related to the significant improvement in the risk-versus-benefit discussions, which were now present in all of the individual records reviewed and the verification that informed consent also had been obtained for the use of these medications.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	The Monitoring Team's initial reports identified deficiencies in the communication of relevant clinical information between the Psychiatrist and the Neurologist for individuals prescribed psychotropic medication to treat seizures and mental health disorders. In response to these observations, the Psychiatry Department had developed a system intended to enhance the communication between the two disciplines. This system, facilitated by the Psychiatric Nurses and the Psychiatry Assistants, was designed to ensure that the Psychiatrist reviewed any recent neurological consultations and documented this review during the next Quarterly Psychiatric Clinic for that individual. Furthermore, the Neurologist was made aware of the individual's psychotropic medication, as well as recent changes in those medications, prior to the next scheduled neurological consultation. This process had now been fully operational for four review	Substantial Compliance

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		cycles. In order to assess the efficacy of this process, the neurology section of the records of the 16 individuals in the review sample were requested. Review of this documentation indicated that the Consulting Neurologist had provided consultation within the past 12 months for the following two (13%) individuals (date of Neurology Consultation): Individual #16 (2/12/14) and Individual #34 (4/17/13). Reference to the most recent Neurology Consultation was located in the Psychiatric Clinic Notes for both (100%) of these individuals. The most recent Neurology Notes also contained a reference to their psychiatric status and medications. In order to increase the size of this sample to make the review more reliable, ten individuals were chosen from the spreadsheet the Facility maintained to track the occurrence of Neurology Consults for individuals also prescribed psychotropic medication. The Clinics that occurred on 2/12/14 and 2/13/14 were chosen. These dates were chosen, as enough time had elapsed since the Neurology Consultation that it would have been reviewed in a subsequent Psychiatric Quarterly or Monthly Review. The ten individuals selected, the date of the Neurology Consultation, and the subsequent Psychiatric Review dates were as follows:	

Individual	Neurology Consultation	Psychiatric Review
Individual #292	2/12/14	3/7/14
Individual #16	2/12/14	3/7/14
Individual #372	2/13/14	3/25/14
Individual #269	2/13/14	3/25/14
Individual #19	2/13/14	3/25/14
Individual #136	2/13/14	3/25/14
Individual #45	2/13/14	3/25/14
Individual #311	2/13/14	3/25/14
Individual #268	2/13/14	2/18/14
Individual #78	2/13/14	2/18/14

This documentation confirmed that the Neurology Consultation Notes contained the relevant information concerning the individual's psychiatric treatment for all of these ten individuals. In addition, the Neurology Note indicated that a member of the Psychiatry Team was present, and that the Neurologist had reviewed the most recent Psychiatric Quarterly Review Notes.

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		At the time of the prior reviews, the Facility had not carried out a formal assessment to determine the amount of Neurology Consultation time necessary to address the needs of CCSSLC, but indicated that if there were a perceived need for additional time, the contract would be extended to provide more Neurology Consultation time. In the interim, since the prior review, there had been a change in the Neurology Consultant, which resulted in an increase in the actual consultation time from one Saturday a month, to three full eight-hour weekdays per month. The change to weekdays made it easier for the Psychiatry staff to attend. The current finding of substantial compliance is based on the finding that the Neurology Note contained adequate reference to the individual's psychiatric status in the two individual records reviewed from the sample, as well as the expanded sample of ten individuals. In addition, the Psychiatric Clinic Note prepared after the Neurology Consult provided a succinct overview of the corresponding Neurological Consultation for each of these individuals. At the time of the onsite review, a member of the Monitoring Team discussed the wording of this provision with members of the Psychiatry Department. Specifically, with particular reference to the language that narrows the scope of this section to the joint coordination of medications "when they are prescribed to treat both seizures and a mental health disorder." The Department members responded that they intended to continue the monitoring of the clinical coordination of all of the individuals who are followed by both disciplines, even though this exceeds the requirements of the Settlement Agreement. In addition, the Chief Psychiatrist indicated that a review of the individuals jointly followed by both Neurology and Psychiatry did not reveal any individuals for whom the same medication was used to treat both seizures and a psychiatric disorder. Accordingly, the Facility was found to be in substantial compliance with this provision of the Settlement Agreement.	

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation of Section K at Entrance Meeting, on 3/31/14; o Section K Presentation Book; o Section K Self-Assessment, updated 3/14/14; o Completed Section K Monitoring Tools: Individual #147, Individual #343, Individual #297, Individual #58, Individual #325, Individual #167, Individual #214, Individual #158, Individual #243, and Individual #332; o Behavioral Health Services Department roster; o Vita, Carolyn Milton, M.S., BCBA, LPC; o Restrictive Practices Committee meeting minutes, from 8/2/13 to 1/31/14; o Behavior Support Committee meeting minutes, from 9/4/13 to 3/27/14; o External Peer Review Committee meeting minutes, dated 9/13, 12/13, and 1/14; o Positive Behavior Support Plan Progress Notes (11/13 to 1/14) for: Individual #297, Individual #58, Individual # 298, Individual #296, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #237, Individual #359, Individual #77, and Individual #141; o Positive Behavior Support Plan Progress Notes (12/13 to 2/14) for: Individual #9 and Individual #191; o PBSP Data Sheets (12/13 to 1/14): Individual #297, Individual #58, Individual #298, Individual #296, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #237, Individual #359, Individual #77, and Individual #141; o PBSP Data Sheet (3/31/14) for: Individual #141, Individual #155, Individual #103, Individual #9, and Individual #46; o PBSP Data Sheet (4/2/14) for: Individual #158 and Individual #58; o Comprehensive Psychological Assessment for: Individual #297, Individual #58, Individual #296, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, and Individual #141; o Comprehensive Psychological Evaluation for: Individual #298; o Behavioral Health Assessment for: Individual #58, Individual #296, Individual #359, Individual #77, and Individual #191; o Psychological Assessment for: Individual #292 and Individual #237; o Psychological Evaluation for: Individual #333; o Structural and Functional Assessment for: Individual #292 and Individual #141; o Structural and Functional Assessment Review for: Individual #146, Individual #237, Individual #359, and Individual 191; o Master List of Individuals Who Have a Behavioral Health Assessment, dated 2/7/14; o Master List of Psychological Assessments with Cognitive and Adaptive Behaviors; o Comprehensive Psychological Assessment for: Individual #35;

	○ Psychological Assessment for: Individual #45; ○ Behavioral Health Assessment for: Individual #78; ○ Admission Behavior Support Plan for: Individual #35, Individual #45, and Individual #78; ○ Counseling Progress Notes for: Individual #172 and Individual #92; ○ Counseling Monthly Review for: Individual #275 and Individual #7; ○ Client Information Form 2 and Counseling Session Notes for: Individual #98; ○ Positive Behavior Support Plan for: Individual #297, Individual #58, Individual #298, Individual #296, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #237, Individual #359, Individual #77, Individual #191, and Individual #141; ○ List of BSC Approval and Consent Dates for PBSPs; ○ PowerPoint presentation on Levels of Supervision; ○ Plan to fade restrictive mechanical restraint utilized with Individual #9; ○ CCSSLC Readability Spreadsheet for All Clients; ○ PBSP Template from Lubbock State Supported Living Center; ○ List of training on PBSPs for the past six months; and ○ PBSP quiz: Individual #297, Individual #58, Individual #298, Individual #296, Individual #9, Individual #310, Individual #307, Individual #146, Individual #292, Individual #359, and Individual #77. ▪ **Interviews with**: ○ Carolyn Milton, Director of Behavioral Health Services, and Everett Bush, Behavior Analyst I, on 4/2/14. ▪ **Observations of**: ○ Infirmary, Dolphin Residence, Ribbonfish Apartment 524-A, Ribbonfish Apartment 524-B, Ribbonfish Apartment 524-C, Ribbonfish Apartment 524-D, Coral Sea Horse Residence, Coral Sea Sand Dollar Residence, Kingfish Apartment 522-A, Kingfish Apartment 522-B, Kingfish Apartment 522-C, and Kingfish Apartment 522-D; ○ Gymnasium; ○ Computer Center; ○ Kaleidoscope, Comfort Zone, Outer Reef Hurricane Alley, Vocational Annex, Vocational Building, and Sailfish Vocational Program; ○ Restraint Reduction Committee meeting, on 3/31/14; ○ Restrictive Practices Committee meeting, on 3/31/14; ○ Skill Acquisition Review Committee meeting, on 4/1/14; ○ Programming Review Committee meeting, on 4/1/14; ○ Internal Peer Review meeting, on 4/2/14; ○ Self-Advocates meeting, on 4/3/14; and ○ Behavior Support Committee, on 4/3/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K, updated 3/14/14. In its Self-Assessment, for each subsection, the Facility had identified: a) activities engaged in to conduct the self-assessment; b) the results of the self-assessment; and c) a self-rating.

	For Section K, in conducting its self-assessment: ▪ Based on a review of the Facility Self-Assessment, the monitoring templates and guidelines, a sample of completed monitoring tools, as well as interviews with staff: o The Facility used two monitoring tools. The monitoring tools the Facility used to conduct its self-assessment included the PBSP Peer Review template and the Behavioral Health Assessment (BHA) Peer Review template. o These monitoring tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. For example, the BHA tool used one indicator to assess compliance with evaluation/assessment results. This did not allow for a comprehensive review of structural and functional assessment methodologies and results. Directions for completing the monitoring tools were not provided. Therefore, it was unclear what criteria were used to determine the score on a three-point scale for the PBSP or a yes/no score for the BHA. o The monitoring tools included adequate methodologies, such as review of documents. o The Self-Assessment identified the sample(s) sizes. o A BCBA Behavioral Health Services Specialist completed the monitoring tool samples provided to the Monitoring Team; o A Quality Assurance staff member had completed inter-rater reliability. The Self-Assessment did not include a report on inter-rater reliability measures. However, in reviewing the documents, it appeared that scores were between 70% and 89% on overall agreement on the PBSP tool, and between 63% and 79% on each of the 19 indicators in this tool. Inter-rater reliability on the BHA tool was 100%. ▪ The Facility used other relevant data sources. For example: o Staff rosters were reviewed and analyzed with regard to demonstrable competence in Applied Behavior Analysis. o Minutes from internal and external peer review meetings were reviewed. o Progress notes for individuals with a PBSP were reviewed. o Staff training curricula and in-service databases were reviewed. ▪ The Facility consistently presented data in a meaningful way. ▪ The Facility rated itself as being out of compliance with 12 subsections of Section K. This was consistent with the Monitoring Team's findings, with the exception of Section K.11. The Facility and the Monitoring Team made findings of substantial compliance with Section K.2.
	Summary of Monitor's Assessment: At the time of the review, the Behavioral Health Services Department had just hired a new Director after six months with this position vacant. Through interviews and observation, it was clear that this person was a very positive addition to the Facility. Areas where concerns were noted were in staff progress in demonstrating competence in applied behavior analysis, data collection, consistent peer review as well as demonstration of the use of the recommendations resulting from the reviews, and provision of counseling services. Continued improvements were needed with regard to the content of monthly progress reports, as well as follow-

	though on recommendations included in the reports. With regard to Positive Behavior Support Plans (PBSPs), a focus for the future should be the development of plans with clear methodology and adequate schedules of teaching identified replacement behaviors, enriched and specific schedules of reinforcement for appropriate and alternative behaviors, and expanded prevention strategies. Areas of strength were in current assessment of cognitive and adaptive behavior skills.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the visit, there were two Department members, one of whom was the Director, who were credentialed as Board Certified Behavior Analysts. Of the remaining 10 Behavioral Health Services staff, two had completed coursework and supervision, four had taken at least one class, two were scheduled to begin classes, and two had not taken any initiative to pursue certification. The Director explained that she was going to follow up with all staff to develop a plan of action. Three positions remained vacant, however, active recruitment of qualified individuals had occurred. The Department had also contracted with a local BCBA who visited once per week to provide supervision and participate in peer review. As the majority of Behavioral Health Services staff who developed Positive Behavior Support Plans were not demonstrably competent in applied behavior analysis, as evidenced by lack of certification, the Facility remained out of compliance with this provision of the Settlement Agreement.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The Facility had recently hired a new Director of Behavioral Health Services. Ms. Carolyn Milton held a master's degree in clinical psychology, was a Board Certified Behavior Analyst, and had over five years experience in the field of human services. She was also a licensed professional counselor in the state of Texas. Her training and experience made her highly qualified for her current position. The facility was found to be in substantial compliance with this provision of the Settlement Agreement.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-	Since the Monitoring Team's last visit, the Behavioral Health Services Department had undergone significant transition. The Director resigned in 9/13, and this position remained vacant until 3/14. The Staff Behavior Analyst put forth a good effort to maintain the peer-review system, but a review of documentation revealed	Noncompliance

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	based system to review the quality of PBSPs.	inconsistencies over the previous six-month period. These findings are presented below. The Behavior Support Committee continued to meet on a regular basis. Although weekly meetings were expected, these did not always occur. Based on a review of meeting minutes between 9/4/13 and 3/27/14, this committee met 23 times during a period where 28 weekly meetings (excluding holidays) would have been expected. Participants were recorded in 22 of 23 minutes. A Department Director was present at three of 22 meetings (14%), a BCBA (Department member, contracted BCBA, and/or State Coordinator) was at 22 of 22 meetings (100%), and other Behavioral Health Services staff were documented as present in only 13 of the 22 meetings (59%). It is unclear whether this was accurate information, because assessments and/or behavior support plans were reviewed in all of these meetings. It is suggested that the individual's clinician responsible for the assessment or plan should be present to receive feedback from his/her peers and supervisors. Although not specifically related to compliance, it was noteworthy that professionals external to the Behavioral Health Services Department were present at 10 of the 22 meetings (45%). Specific attendance by the following disciplines and facility administrative staff were: psychiatry (36%), nursing (27%), residential (18%), quality assurance (14%), administration (14%), and habilitation therapies (5%). Attendance by these external Facility staff members was not evident at any of the meetings held since the beginning of the year. During the identified time period, minutes reflected a review of 18 evaluations or assessments, 67 PBSPs, and one Crisis Intervention Plan. Minutes were requested from the meetings of the External Peer Review Committee over a six-month period. The Facility provided minutes from three meetings, including those held in 9/13, 12/13, and 1/14. Attendance at these three meetings was as follows: State Coordinator of Behavioral Health Services (100%), Department BCBA (100%), one to two Behavioral Health Specialists (100%), one BCBA from Abilene State Supported Living Center (100%), and the contracted BCBA (33%). It was unclear why there was no involvement of staff from Austin or Lubbock State Supported Living Centers as multiple experts can enhance the peer review process. Documentation regarding external peer review feedback was evident for only two of the three meetings (67%). Brief notes were included in documentation from the review scheduled in 1/14. An ISP Addendum meeting was held six days following the external peer review for Individual #348 held in 12/13. The feedback was reviewed and the team agreed to address all items. Responsible staff and completion dates were identified. This provided a good example of how the external peer review process can be utilized to best meet the needs of the individual. Until there is evidence of weekly meetings of the Behavior Support Committee, monthly meetings of the External Peer Review Committee with adequate response to the feedback	

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		provided, and an ongoing mechanism for reviewing difficult cases, the Facility remains out of compliance with this provision of the Settlement Agreement.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	A request was made for three months of Positive Behavior Support Plan Progress Notes for the 16 individuals in the sample. The progress notes for Individual #58 were not provided. As Individual #333 did not have a PBSP, no progress notes were available for review. This resulted in a review of 42 monthly progress notes for 14 individuals in the sample. A summary of findings is provided below. ▪ Behaviors targeted for reduction were identified and graphed in all of the progress reports (100%). o Staff should record "no data" when data sheets cannot be found for the month. There should be no data point depicted on the graph, resulting in a break in the data path. Progress or the lack thereof on related treatment objectives should also be left blank when there is missing data. ▪ In 38 of the 42 reports (90%), replacement behaviors were identified and graphed. The 11/13 report for Individual #298 included a graph for only one of two identified replacement behaviors, and while the three monthly reports for Individual #237 noted whether or not he had made progress on his replacement behavior, there were no graphs included. o Graphing conventions described above also apply to replacement behaviors. Problems with missing data were found in the following progress notes: Individual #297 (replacement behavior 11/13 and 12/13), Individual #298 (all graphs 11/13), Individual #296 (problem solving 11/13), and Individual #191 (replacement behavior 2/14). ▪ In the progress notes for all but one individual, all of the graphs depicted monthly frequency of the targeted problem behavior(s) and the replacement behavior(s). While monthly frequency was the measure depicted in four of the graphs displayed in the reports for Individual #9, his reports also included two graphs that depicted the average daily hours per month that he did not exhibit self-injury and the average nightly hours per month that he slept. o Monthly averaging of data can mask changes that occur in behavior due to introduction of new programs, change in living or working environment, illness, or changes in medication. An example of the difficulty in monthly reporting was found in the 1/14 progress note for Individual #298. The graphs that depicted disruptive behavior, self-injury, and two replacement behaviors actually reflected only five days of data collection, because a new PBSP was introduced on 1/6/14. o Staff should carefully proof all documents to ensure correspondence between information presented graphically and in the text. For example, the summary statement in the 12/13 progress note for	Noncompliance

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		Individual #9 suggested that his self-injurious behavior had decreased, when the graph indicated that it had increased. Similarly, the summary statement in the 12/13 progress note for Individual #359 suggested that his aggression had improved, while the graph clearly indicated that it was worse than the two previous months. ▪ None of the 42 progress notes (0%) included data reflecting monitoring of PBSP implementation (i.e., treatment integrity). ▪ Thirteen of the 42 progress notes (31%) reported on monthly inter-observer agreement on targeted problem behavior. Although this was appropriate, it was concerning that in eight of these reports (i.e., for Individual #307, Individual #146, Individual #292, and Individual #77) inter-observer agreement was obtained between two members of the Behavioral Health Services Department. It would be preferable to assess inter-observer agreement between department staff and a direct support professional responsible for daily data collection. ▪ Twenty-seven of the 42 progress notes (64%) indicated whether or not the individual had a Crisis Intervention Plan. Only Individual #191 had a plan utilized in his home. It was concerning that there was no plan for Individual #297, because her progress notes included a graph depicting occurrences of restraint. This suggested that this occurred on a regular basis and therefore a crisis plan should have been developed. ▪ Progress notes for eight individuals in the sample included information regarding the individual's involvement with counseling services. For seven of these eight individuals, it was noted that he/she did not receive counseling or this service was not applicable. Individual #191 had been referred and approved to begin counseling services. His team was to meet with the identified counselor to provide background information and develop a schedule. It was concerning that these statements were repeated in all three monthly progress notes. It is suggested that counseling should have been initiated in a timely manner. ▪ Thirty-six of the 42 progress notes (86%) included information regarding desensitization plans. Individual #9 and Individual #310 had identified desensitization objectives. Individual #159 and Individual #141 were deemed not appropriate candidates for desensitization programs based as determined by the Decision Tree. It was concerning that desensitization was noted as "not applicable" for four individuals who had been identified in their Integrated Risk Rating Form as requiring pre-treatment sedation for dental work. The four individuals were Individual #298, Individual #307, Individual #146, and Individual #77. If a determination had been made that they were not candidates for desensitization plans, this should be noted in the progress note. ▪ Each progress note (100%) ended with a section regarding recommendations. Individual-specific concerns are provided below:	

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		○ The 12/13 progress note for Individual #296 indicated that "escape" would be a new replacement behavior. This was recommended at his annual meeting in mid-December, yet the same recommendation was included in his progress note from 1/14. It was unclear why this plan had not been developed and implemented. ○ For three consecutive months, one of the recommendations for Individual #237 was to "create behavior objective for his replacement behavior." This should have been completed. ○ For two consecutive months, it was noted that a new PBSP had been developed for Individual #141. By the third month, there was no indication that this had been implemented, because there was no report on her self-injurious behavior, which was addressed in the new plan. A more timely implementation of plans is necessary, particularly when these address serious problem behaviors. ○ For two consecutive months, one recommendation for Individual #159 was to continue training on her new PBSP. This statement was confusing, because elsewhere in the reports it was noted that: "her new PBSP was implemented three months ago." Further, the graphs suggested that her new PBSP had been introduced in January of 2013. ○ For three consecutive months, the only recommendation for Individual #310 was to "continue working to find a group home placement." While this may be a very appropriate recommendation, there were other issues that should have been addressed. In each progress note, there was a statement indicating that his participation in a medical desensitization plan was decreasing. It was noted that: "we will need to talk to staff as to the cause." It appeared that this was never addressed, because by 1/14 an additional statement indicated the objective was going to be discontinued. ▪ Thirty-three of the 42 progress notes (79%) were signed and dated within 30 days. Data sheets for targeted problem behaviors identified in the PBSP for 13 individuals were reviewed. Data sheets for three additional individuals had been requested, but these were either not provided or the individual did not have a PBSP. For all 13 individuals in the final sample, data was provided between 12/13 and 2/14. A summary of the findings is presented below: ▪ For 11 of 13 individuals (85%), the frequency of occurrence within three, eight-hour shifts throughout a 24-hour period were collected on all targeted problem behaviors. The exceptions were Individual #297 and Individual #310 whose targeted problem behavior was recorded within hour blocks of time. Environmental sweeps and individual checks were conducted every half hour	

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		with Individual #310 between the hours of 10 p.m. and 6 a.m. There were problems with the data sheets in which frequencies of targeted behavior were recorded per shift. First, expecting staff to recall events at the end of an eight-hour shift is likely to lead to inaccurate recording. Second, the space available for recording targeted problem behavior was very small, likely leading to under-recording. In fact, many data sheets reflected a record of problem behavior, but no indication of the frequency of occurrence. ▪ For 10 of the 13 individual in the sample (77%), there were days with missing data. As noted above, although some progress notes included a report of missing monthly data, a data point of zero was recorded on the graph. This practice should be discontinued. ▪ In 34 of the 43 replacement behavior data sheets (79%), it was evident that the individual had successfully practiced the behavior in over 50% of the days of the month. Individual #298 and Individual #296 were examples where replacement behaviors were practiced nearly every day. Individual #141 was an example where there were limited opportunities to practice her replacement behavior. ▪ Data sheets for 10 of the 13 individuals (77%) included space to record utilized intervention strategies and delivered reinforcement. It was concerning that these were identical across individuals, because this suggested that the PBSP was not specific to the individual. For nine of the 10 individuals for whom reinforcement was recorded (90%), it appeared that social praise was applied the majority of the time. Social praise might not always be sufficiently motivating to the individual and is often dependent upon the relationship the individual has with the person delivering the praise. During the week of the Monitoring Team's visit, there were several occasions when problem behaviors were observed. A request was made for the data sheets from the week of the visit that were used to track the frequency of targeted problem behaviors. A summary of findings is provided below. ▪ For all of the individuals observed (who had PBSPs), data was recorded per eight-hour shift. As noted above, there are concerns about the accuracy of data when staff are expected to recall events at the end of their shift and when the actual space for recording is so small that it physically limits the number of events that can be documented. ▪ On 3/31/14, the following events were observed: o Individual #349 was observed at 10:41 hitting his ear four times. Staff reported that he did not have a PBSP, therefore, there was no documentation of this behavior. Although the staff in the home interpreted this behavior as a request for a radio, the Facility should consider developing a PBSP to help eliminate this self-injurious behavior.	

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		○ Individual #141 was observed hitting staff and attempting to pull down her pants at 10:59. Both behaviors were recorded during the 6 to 2 shift. ○ Individual #155 was observed throwing herself against the back of her wheelchair. Although this was not recorded because it was not included in the definition of her self-injurious behavior, it is suggested that staff might want to review the varied topographies of this behavior. ○ Individual #103 was observed at 11:01. She was hitting staff, attempting to remove her shirt, and hitting and biting herself. Although the first two behaviors were documented, her self-injurious behavior was not recorded, nor was this identified on her data sheet. ○ Individual #9 was observed at 11:20. He hit his head four times and hit his legs. Although self-injury was recorded on the 6 to 2 shift, the number of occurrences was not identified. ○ Individual #31 was observed bucking in his wheelchair and biting himself at 11:15. The Facility reported he did not have a PBSP, therefore, he had no data sheet. Staff should meet with his team to determine whether a PBSP is warranted. ○ Individual #46 was observed threatening others between 4:30 and 4:35. Although this was recorded during the 2 to 10 shift, the frequency of the behavior was not evident. ○ On 4/2/14, Individual #58 was observed at 3:57. He was throwing items, attempting to pick up the table, and trying to scratch a visitor's hand. Although hitting, kicking, and throwing were recorded during the 2 to 10 shift, there was no information regarding the frequency of these behaviors. Continued improvements were needed with regard to the content of monthly progress reports, as well as follow-though on recommendations included in the reports. In addition, clinical decisions are made based upon data that is very likely inaccurate and unreliable. Behavioral services staff should work closely with direct support professionals to ensure that data collection systems are manageable and completed with integrity. Continued training, oversight, and assessment of inter-observer agreement will be necessary. Based on observation and review of documents, the Facility remained out of compliance with this section of the Settlement Agreement.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological	The psychological or behavioral health assessment was reviewed for the 16 individuals in the sample. It should be noted that the exact title of this document varied across individuals. When it was provided, the Structural and Functional Assessment (SFA) or the Structural and Functional Assessment Review (SFAR) were also examined. Information regarding a functional behavior assessment was included in the documents	Noncompliance

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	assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	for 12 of the 16 individuals. Individual #333 did not have a PBSP, therefore an assessment of behavior function had not been completed. The information provided for Individual #237 and Individual #307 was incomplete. There was no information regarding a functional behavior assessment included in the document for Individual #77. The functional behavior assessment is completed to determine the variables that contribute to the occurrence of problem behavior, to determine the hypothetical function of the problem behavior, and to help guide the development of the behavior support plan. A summary of the review findings is provided below. ▪ The 12 reports were completed between 5/18/13 and 1/31/14. Eleven of the 12 reports (92%) were completed before the individual's annual meeting. The exception was Individual #159. Four of the reports included the date of approval by the Behavior Support Committee. Approval was obtained between 1.5 and four months after the report was written. o Of concern was the information reviewed to determine behavioral function for Individual #191. His SFAR indicated that the assessment of behavioral function had been completed three years earlier. As this is an individual with a high risk rating for behavioral health, it is recommended that an updated structural and functional assessment be completed. Department policy also requires a full structural and functional assessment every three years. ▪ Ten of the 12 assessments (83%) identified both indirect and descriptive methods of determining behavioral function. The exceptions were the assessments for Individual #359 and Individual #191. Information regarding the functional behavior assessment was obtained from the SFAR, which did not specify the method used to identify behavioral function. In the future, it would be helpful if information regarding methodology and completion date were included in these reviews. ▪ Specific instruments used for indirect assessment were the Questions About Behavioral Functioning (QABF), the Motivation Assessment Scale (MAS), and/or the Functional Assessment Interview Form (FAIF). Of the 10 assessments in which these tools were reviewed, five (50%) included a date of completion that reflected information gathered within one month of the report. Four reports included indirect assessment information from the previous year. As rating scales and interviews can be conducted in a brief period of time, it is suggested that these be repeated annually. Staff should carefully proof all documents as some reports included information that postdated the date of the report. For example, the reports for Individual #297, Individual #296, and Individual #9, included information from rating scales and/or staff interviews that were completed after the date of the report. ▪ Ten of 12 reports (83%) indicated that direct observations had been completed. In nine of these 10 reports (90%), a brief description of the events observed was	

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		provided. The exception was the report for Individual #292. As noted above, staff should carefully proof all documents as some reports included information that postdated the date of the report. The reports for Individual #297, Individual #9, and Individual #310 included information from observations conducted after the report dates. ▪ All of the reports (100%) identified setting events, antecedent stimuli, and consequences to the targeted problem behaviors. Where appropriate, medical and/or psychiatric variables were identified. ▪ Eleven of 12 assessments (92%) included the identification of specific replacement or alternate behavior. The replacement behavior was not identified in the report for Individual #359. Individual specific concerns are reviewed below: o Individual #296 was to learn to request a break as a means of escape. However, his assessment also identified access to tangibles as a possible function of his aggressive behavior. This should have been addressed as well. o It was hypothesized that Individual #9 engaged in self-injury for sensory feedback. The replacement behavior was to tolerate having his hands washed followed by the application of lotion. It is unclear how this will serve as a functionally equivalent response. o One proposed replacement behavior for Individual #146 was for her to learn to count as a means of relaxation when she was being transferred for self-care activities. This did not provide her with a means to escape, which was the proposed function of her aggression. ▪ Graphs depicting the frequency of targeted problem behaviors were included in 11 of 12 reports (92%). The exception was the report for Individual #191. All of the graphs depicted monthly frequencies of targeted problem behavior. Data paths were connected across all phases depicted in the graphs. This practice should be discontinued. ▪ Individual preferences were reported in 11 of the 12 reports (92%). Individual #298 and Individual #296 had been interviewed within one month of the report. A structured preference assessment was identified for Individual #159 and Individual #141, however the dates of completion were either not identified or were over one year old. None of the other seven reports in which preferences were listed noted the date of assessment. As individual preferences can change over time, these should be completed frequently, particularly when behavior is not improving or when changes are observed in the individual. As noted above, all documents should be carefully proofed. The interview conducted with Individual #296 to determine his preferences was conducted after the date of the report. ▪ All of the 12 reports (100%) were signed.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Although the Facility had made progress in ensuring standard presentation of annual Behavioral Health Assessments, these were not consistently updated or completed within expected timeframes. Further, the quality of these assessments varied across individuals. Continued emphasis should be placed on observation of the individual in his/her home, work, and leisure environments, with thoughtful suggestions for prevention strategies and functionally equivalent replacement behaviors. Annual assessments or updates will need to be completed for each individual by his/her ISP meeting. For these reasons, the Facility remained out of compliance with this provision of the Settlement Agreement.</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>A review was conducted of the most recent psychological or behavioral health assessment provided by the Facility for each of the 16 individuals in the sample. The Facility's master list of assessments also was reviewed. The table below lists the date of the assessment provided to the Monitoring Team, the most recent assessment of cognitive abilities and adaptive behavior, and the most recent Inventory for Client and Agency Planning (ICAP), required every three years. The most recent date is provided whether this was found in the individual's most current assessment/evaluation or on the master list. An asterisk indicates a lack of correspondence between these two documents.
<table>
<tr><th>Individual</th><th>Psychological Assessment/BHA</th><th>Cognitive</th><th>Adaptive</th><th>ICAP</th></tr>
<tr><td>Individual #297</td><td>10/7/13*</td><td>3/16/12</td><td>5/23/13*</td><td>3/7/12</td></tr>
<tr><td>Individual #58</td><td>11/21/13*</td><td>12/30/11</td><td>2/28/12</td><td>1/24/12</td></tr>
<tr><td>Individual #298</td><td>6/13/13*</td><td>1/19/12</td><td>10/23/12</td><td>7/26/12*</td></tr>
<tr><td>Individual #296</td><td>11/11/13*</td><td>1/19/12</td><td>10/24/12</td><td>2/9/12</td></tr>
<tr><td>Individual #9</td><td>5/18/13*</td><td>6/16/11</td><td>6/6/12</td><td>1/18/13</td></tr>
<tr><td>Individual #159</td><td>8/12/13*</td><td>11/28/11</td><td>8/8/12</td><td>6/6/13</td></tr>
<tr><td>Individual #310</td><td>11/14/13*</td><td>12/30/11</td><td>3/20/12</td><td>8/6/13*</td></tr>
<tr><td>Individual #307</td><td>9/11/13*</td><td>11/22/11</td><td>9/26/12</td><td>7/26/12</td></tr>
<tr><td>Individual #146</td><td>10/23/13</td><td>8/12</td><td>8/10/12</td><td>7/26/12</td></tr>
<tr><td>Individual #292</td><td>9/11/13</td><td>8/9/12</td><td>7/26/12*</td><td>12/15/11</td></tr>
<tr><td>Individual #333</td><td>8/26/13</td><td>7/19/12</td><td>6/16/12</td><td>5/16/11</td></tr>
<tr><td>Individual #237</td><td>10/2/13</td><td>11/1/01</td><td>9/27/12</td><td>12/7/12</td></tr>
<tr><td>Individual #359</td><td>12/5/13*</td><td>3/22/12</td><td>3/20/12</td><td>2/16/12</td></tr>
<tr><td>Individual #77</td><td>10/8/13*</td><td>6/27/90</td><td>9/4/12*</td><td>5/30/13</td></tr>
<tr><td>Individual #191</td><td>1/31/14*</td><td>3/20/12</td><td>4/12/12</td><td>1/7/11</td></tr>
<tr><td>Individual #141</td><td>9/24/13</td><td>12/29/11</td><td>10/4/12</td><td>10/3/12</td></tr>
</table></td><td>Noncompliance</td></tr>
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		According to these records, 16 of 16 individuals (100%) had a current psychological or behavioral health assessment, 14 of 16 individuals (88%) had a cognitive assessment completed within the last five years, 16 of 16 individuals (100%) had an adaptive behavior assessment completed within the last five years, and 15 of 16 individuals (94%) had an ICAP completed within the last three years. For eight of the 16 individuals in the sample, there was evidence that a Reiss Screen for Maladaptive Behavior had been completed within 12 months of the current psychological or behavioral health assessment. Although the Facility had clearly made progress in ensuring that all required assessments are current, the accuracy of the clinical and behavioral data remains questionable as reviewed in Section K.4 of this report. This provision of the Settlement Agreement clearly requires that: "psychological assessments are based on current, accurate, and complete clinical and behavioral data." As a result, the Facility remains out of compliance with this provision of the Settlement Agreement.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	Since the last review, three individuals had been admitted to the Facility. A psychological or behavioral health assessment and an admission behavior support plan were developed and reviewed for all three individuals. A summary of findings is provided below. ▪ For two of the three individuals (67%), the assessment had been completed within one month of admission. The exception was individual #45 whose assessment was completed 34 days after his admission. ▪ It was concerning that in all three reports, assessment information gathered after the date of the report was included. For example, the results of client and staff interviews, observations, a behavioral function rating scale, and a measure of adaptive behavior, all completed after the report date, were included in the assessment for Individual #35. Additionally, data was presented through 11/13 although the report was dated 8/13. Similarly, the results of a Reiss Screen completed with Individual #45 and Individual #78 after their report dates were described. This called into question whether or not the reports actually were completed within 30 to 34 days of the individuals' admissions. ▪ Staff should carefully proof all documents to ensure that the information provided is accurate and consistent throughout. It was noted in the report for Individual #78 that this was his second admission to CCSSLC, but his documented history suggested that this was his third admission. There were also inconsistencies regarding intellectual disabilities, with reports ranging from moderate to severe/profound. ▪ All three individuals had an Admission Behavior Support Plan (ABSP) developed within days of their admission to the Facility. There were some inconsistencies	Noncompliance

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		found in these documents as well. The date of admission for Individual #45 was different on his ABSP than his psychological assessment. Further, his assessment noted the presence of both aggression and self-injury, but only the latter was addressed in his ABSP. Self-injury was hypothesized to serve as a means of obtaining a tangible item or gaining attention, yet the teaching protocol addressed teaching him a means of escape. As noted in Section K.6, the Facility had clearly made progress in ensuring that all required assessments were current. Due to the problems identified in the assessments for newly admitted individuals, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	At the time of the visit, counseling services were in transition. The Department reported that since the last review, only five individuals had been involved in counseling. Community-based services had been terminated and Department staff struggled to continue to provide services. A new counseling position was created, and following a job posting and interviews, a staff member was identified. The plan was to move a current Behavior Health Specialist who holds a license as a professional counselor into this position. As noted by the Director of the Department, it would be preferable to arrange for the provision of counseling services by independent practitioners in the community. As the Department re-introduces counseling services, there are several components that must be addressed. Referrals must be tracked and responded to in a timely manner, counseling plans must be developed and include behavioral objectives that identify the conditions under which observable behavior will occur with measurable mastery criteria, and progress notes must reflect data-based assessment of treatment efficacy. Lastly, it will be important to ensure that evidence-based approaches are utilized in the provision of counseling services. At this time, the Facility remained out of compliance with this provision of the Settlement Agreement.	Noncompliance
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been	The Positive Behavior Support Plan was provided for 15 of 16 individuals in the sample. The Facility reported that Individual #333 did not have a PBSP. This was concerning, because other documents indicated that he engaged in self-injurious behavior and aggression. He also was reported to have recently refused to get up or walk, and his ISP indicated that g-tube feedings were necessary when he refused to consume food orally. These are clearly issues that should be addressed by the interdisciplinary team, with the lead taken by Behavioral Health Services staff. The 15 PBSPs were reviewed to determine whether essential elements were included in each plan. A summary of this review is provided below. ▪ Fourteen of the 15 plans (93%) identified the implementation date. Three were implemented less than one month after the individual's ISP, five were	Noncompliance

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	resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	implemented one to two months after the ISP, five were implemented two to four months after the ISP, and one was implemented approximately one month before the ISP. Nine of the 15 plans (60%) identified the date of BSC approval. The master consent/approval list identified BSC approval for three additional plans. This same master list identified consent dates for 12 of the 15 plans (80%). In the future, it would be helpful if all plans included the ISP date, the BSC approval date, and the implementation date. It also would be helpful when the approval of the Human Rights Committee was required, if the PBSP indicated when this was obtained. Timely review and implementation of all PBSPs is essential to ensure appropriate supports for the individuals served. ▪ A rationale for the PBSP was provided in 12 of 15 reports (80%). The exceptions were the plans for Individual #237, Individual #359, and Individual #191. Each of these plans followed an updated format that might have to be reconsidered for future use, because it did not contain all necessary elements. ▪ Operational definitions of targeted behaviors were included in all of the PBSPs (100%). However, concerns were identified in several plans: o Two problem behaviors, self-injury and disruptive behavior, exhibited by Individual #298 were no longer included in her PBSP, although the graphs for both indicated an increasing trend. o The rationale provided in the PBSP for Individual #310 noted that the plan was developed to help reduce his aggressive behavior. Aggression was not one of his targeted problem behaviors. o The PBSP for Individual #237 included two different definitions of aggression. ▪ All of the PBSPs (100%) identified the potential function of the targeted problem behaviors. ▪ Operational definitions of alternative or replacement behaviors were included in six of 15 PBSPs (40%). The six plans were for Individual #297, Individual #58, Individual #296, Individual #292, Individual #359, and Individual #141. ▪ Strategies for teaching alternative or replacement behaviors were identified in 14 of 15 plans (93%). However, specific schedules for teaching these behaviors were identified in only six of the 15 plans (40%). The plans for Individual #310, Individual #191, and Individual #77 indicated that a teaching opportunity should be provided once per day. The three other plans (i.e., Individual #9, Individual #359, and Individual #141) identified two to four opportunities per day. As has been noted in the past, frequent opportunities should be scheduled to ensure that learning occurs. Individual specific comments are provided below. o The methodology for teaching Individual #297 to obtain attention included directions to staff that they should approach her and state: "let's practice your FERB [functionally equivalent replacement	

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		behavior]." This is a very unnatural statement and is not likely to aid in the individual's generalization of this skill to situations outside of the training environment. o Although a timer was suggested to help Individual #298 learn to wait for a requested preferred item, it would be advisable to also identify activities she could engage in while waiting. o Individual #307 was to access materials that would provide her with sensory feedback. Throughout the plan, there was conflicting information as to what these materials were (e.g., noise makers, spinning tops, chewy tube, or jar with blocks). Staff should make every effort to present clear and consistent guidelines to staff. o Individual #146 was to learn to count and take deep breaths, but neither of these responses gave her a means to escape activities she found unpleasant. Further, staff were to ask her if she was afraid she might fall. It would make more sense to assure her that she was safe, to associate transfers with preferred items/people, etc. It would also be advisable to offer more specific strategies for working with this woman who is legally blind. o Individual #292 was learning to state: "Go," when he wanted to escape an activity. It was noted that staff would need to prompt this skill. As verbal behavior is very difficult to prompt and he is difficult to understand, it might be more appropriate to teach him some gesture or simple motor response paired with verbal communication. Staff were also advised to teach him this replacement behavior if he did not want to get up in the morning and began hitting. It would be advisable to teach this response before he displayed aggressive behavior. o Individual #191 was to learn to wait for 15 minutes after asking to speak with a staff member. It was unclear why he must wait that long to talk with a staff member. Unless he is provided something to do during this waiting period, it is very likely that this will not be successful. ▪ Preventative strategies were included in eight of 15 PBSPs (53%). The breath and quality of these strategies varied across plans. Individual-specific comments are provided below: o Prevention guidelines for Individual #297 were a repetition of the replacement behavior. These did not offer suggestions for activities that would provide her with attention from staff. o Similarly, the plan for Individual #159 repeated information about replacement behaviors in the prevention section. o The plan for Individual #9 directed staff to remove him from loud and noisy environments when increased self-injury was observed. A more appropriate prevention strategy would be to remove him before he	

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		displayed self-injury. o The plan for Individual #141 provided the same guidelines in the prevention section as the intervention section. If she began biting herself, staff were to tell her: "that's not the best way to get my attention." This response provided attention. ▪ Schedules of reinforcement were identified in three of 15 PBSPs (20%). Individual #297 was to receive praise every hour for the absence of identified problem behavior. Individual #307 was to be praised every hour when she was observed manipulating preferred items. Four times daily, Individual #298 was to receive praise and either two "Campus Bucks" or a small diet soda for waiting appropriately for a requested item. It is recommended that all plans should include a structured and dense schedule of differential reinforcement, either for the absence of targeted problem behavior, for displaying lower rates of the targeted problem behavior, or for displaying incompatible or alternative behavior. ▪ Consequences for targeted problem behaviors were identified in all of the PBSPs (100%). Ten of the 15 PBSPs (67%) included instructions to staff to tell the person to stop displaying the behavior. Staff are cautioned to ensure that appropriate language and clear directions are provided in each plan. Individual-specific examples are provided below: o The plan for Individual #58 noted that if he did not stop engaging in problem behavior when told to do so, he should be removed to a quieter area. As problem behavior was more likely to occur in a crowded environment, this consequence might actually strengthen aggression or self-injury. o Contingent upon self-injury, staff were to provide Individual #77 with a vibrating pillow. As this was an identified preference, this might strengthen the targeted problem behavior. ▪ Potential reinforcers were listed in all of the PBSPs (100%). ▪ Baseline or comparison data were provided in 13 of the 15 PBSPs (87%). ▪ Instructions for data collection were included in all of the plans (100%). ▪ All of the PBSPs were signed (100%). In the months preceding the Monitoring Team's onsite review, the team for Individual #72 had reduced his level of supervision from one-to-one to routine. While on routine supervision, he engaged in an unauthorized departure and weeks later he was found dead. Although it is important for teams to ensure the least restrictive levels of supervision are in place, it is essential that the process for reducing levels of supervision for behaviors that have the potential to place the individual at risk is carefully orchestrated with the involvement of BCBAs. As was discussed while the Monitoring Team was on site, when fading of restrictive practices or one-to-one or enhanced levels	

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		of supervision due to risky behaviors, staff should attend to the following guidelines: ▪ Brief attempts to fade restrictive practices or increased levels of supervision could be probed by clinical staff who would then develop carefully designed written programs for direct support staff to implement. ▪ Fading programs should include the following: o Objective measures of operationally defined successful behavior(s) and behavior(s) that would trigger reconsideration of attempts to fade supports; o Frequent and structured assessment of preferences so potentially powerful reinforcers could be applied to ensure positive behavior change; and o Ongoing oversight and supervision by Behavioral Health Services staff. ▪ Consideration should be given to presenting all fading plans to internal and external peer review. When reviewing the fading plan for Individual #9, concerns were raised because the guidelines included providing him with activities he preferred if he tried to hit himself or others when his mitten were removed, and providing him with "lots of attention" if he attempted to hurt himself. Either of these strategies could potentially increase the frequency of his problem behavior when out of restraint. Based upon the review of the Positive Behavior Support Plans for the 15 individuals in the sample, the Facility remained out of compliance with this provision of the Settlement Agreement. A focus for the future should be the development of plans with clear methodology and adequate schedules of teaching identified replacement behaviors, enriched and specific schedules of reinforcement for appropriate and alternative behaviors, and expanded prevention strategies. Consents should be carefully tracked with the identified implementation date recorded.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and	As noted above with regard to Section K.4, for 14 of 14 individuals in the sample, all or most of the graphs included in their psychology progress notes depicted the total monthly occurrence of targeted behaviors. Axes were labeled (broadly), and data points and paths were displayed. For 10 of the 14 individuals, phase change lines were used to depict baseline and treatment conditions. For Individual #159 and Individual #359, a phase change line was included to reflect a new PBSP. For Individual #146 and Individual #141, a change in medication was noted with a phase change line. No other changes were reflected on the graphs. Data points were connected across phase changes, a practice which should be discontinued. As has been noted with regard to Section K.4, concerns remained regarding the accuracy of reported data. Data collection across eight-hour shifts can result in inaccurate and possibly under-recording of data. In the progress notes reviewed with regard to Section K.4, reports of inter-observer agreement were included in only 13 of 42 reports (31%). As noted above, staff should collect measures of	Noncompliance

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	impact of psychotropic medications.	inter-observer agreement between direct support professionals and supervising clinicians. This will help identify observer drift, poor or limited understanding of operationally defined behavior, or other matters that may compromise the accuracy of data. Staff also should consider alternative means of depicting data. Monthly data display can mask critical changes in behavior that result from changes in intervention, changes in medication, including subtle changes to dosing, changes in environment or habilitation activities, and changes related to health issues. Staff should provide graphic display of targeted behaviors in a manner that will allow analysis of the effects of planned and unplanned changes. Although there was evidence of monthly review of progress, the Facility remained out of compliance with this provision of the Settlement Agreement. Data collection remained compromised, monthly assessment of inter-observer agreement was not yet fully implemented, and graphing conventions did not allow for adequate review of progress.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	As reported by the Facility, PBSPs were assessed for readability during the annual internal peer review process. The Behavior Support Committee utilized the Flesch-Kincaid readability test to determine grade level of all plans. According to the Readability Spreadsheet the Facility provided, the plans for the 15 individuals in the sample had a readability level between grades 5.6 and 10.5. The average grade level was 6.9. A review of all PBSPs listed on the Readability Spreadsheet indicated that 99 or 114 plans (87%) were written at or below an eighth-grade level. The 15 plans written above an eighth-grade reading level should be reviewed to ensure these can be clearly understood and implemented by all staff. An introduction of a PBSP format similar to the one used in the Lubbock State Supported Living Center should make this document even clearer and more comprehensive. The Facility was found to be in substantial compliance with this provision of the Settlement Agreement.	Substantial Compliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the	New employee training consisted of one afternoon of didactic instruction addressing Positive Behavior Support, individual specific written quizzes for each person who had a PBSP, and competency-based training utilizing the "Staff Instructions" section of the newly revised PBSP. It should be noted that although written quizzes were requested for 15 individuals, the Facility provided documents for only 11 individuals. No further explanation was provided. The training roster provided to the Monitoring Team indicated that over a six-month period, training had occurred on PBSPs for 19 individuals. With a total of 114 individuals with PBSPs, this is a small and concerning number. The data did not indicate who or how	Noncompliance

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	implementation of those plans.	many staff had been trained or how the individuals for whom staff needed to demonstrate competency on the implementation of their PBSPs had been selected, nor did it specify whether training involved didactic instruction, role-play, or competency-based training. As the parties agreed, the Facility should describe in its policy and show that it implements the following: ▪ Staff on-the-job training (OJT) integrity checks of implementation (i.e., who, what percentage, how often, etc.); ▪ Which PBSPs must <u>all staff</u> working with the individual have demonstrated OJT integrity checks (e.g., high risk, dangerous violence); and ▪ Demonstration of competence for challenging behaviors that occur very infrequently. The Facility did not present evidence that adequate and on-going competency-based training was occurring, or that it had or was implementing a policy with the necessary components. For this reason, the Facility remains out of compliance with this provision of the Settlement Agreement.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the visit, 231 individuals were in residence at the Facility. Employed within the Behavioral Health Services Department were a Director, one additional BCBA, and 10 Behavioral Health Specialists. In addition to having clinical caseloads, one Behavioral Health Specialists was identified to begin providing counseling services once Department vacancies were filled. The Department also employed five assistants who supported clinical care. At the time of the visit, there were three vacant Behavioral Health Specialist positions and two vacant Behavioral Health Assistant positions. At the current staff levels, the ratio of master's level Department staff to individuals served was 1:21. Once the assistant positions were filled there would adequate support for the clinical staff. Although the Department employed a sufficient number of professionals to maintain an average ratio of one for every 30 individuals, the Facility remained out of compliance with this provision because only one of the Behavioral Health Specialists had demonstrated competency in Applied Behavior Analysis as evidenced by certification.	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of all staff who work in the Medical Department, including names and titles; o Name and CV of Medical Director, if new since the last visit; o Name and degrees of all Primary Care Providers that were new to the Facility since last Monitoring Team visit; o Number of individuals on each PCPs caseload; o Employees listed under Medical Department completing CPR training certification with dates of completion, and dates of expiration; o Copy of any in-service for PCP training on ICD and DSM diagnostic criteria in last six months; o Since the last onsite review, copy of CME for each Primary Care Provider, list of CME credits according to topics reviewed, and list per PCP of total CME credits during this time period; o Copy of any clinical guidelines developed and implemented since last Monitoring Team visit; o Minutes of Infection Control (IC) committee meetings during the prior six months; o Minutes of skin integrity committee meetings during the prior six months; o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken, including date of audit from which information retrieved; o For each PCP, two most recently completed quarterly medical reviews from each assigned residence for following individuals: Individual #369, Individual #242, Individual #218, Individual #7, Individual #167, Individual #299, Individual #77, Individual #293, Individual #70, Individual #21, Individual #232, Individual #340, Individual #239, Individual #3, Individual #87, Individual #91, Individual #333, Individual #338, Individual #89, Individual #65, Individual #329, Individual #53, Individual #5, Individual #177, Individual #296, and Individual #279; o For any medical staff meetings (i.e., morning medical meetings etc.) copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed, for the week prior to the Monitoring Team's visit; o Most recent results/report of the Facility-wide medical review system, including copy of any non-facility physician review reports or data since the Monitoring Team's last visit, with separate reports/data of external medical peer review audits from internal medical peer review audits (both general medical and medical management audits), including information concerning number of corrective action plans, and QA Department follow-up of these corrective action plans; o List of individuals who died since the Monitoring Team's last visit. For each individual, submitted information included date of death, death certificate, whether autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and

	for seven days prior to death or hospitalization, all clinical documentation including nursing and physician notes, and all diagnostic studies including radiologic and laboratory. Submitted, requested information included location at time of death, whether DNR, whether receiving hospice services, ambulatory status, and whether supplemental oxygen prescribed as part of routine care. Information submitted for following individuals: Individual #43, Individual #183, and Individual #72; o Mortality Reviews (i.e., clinical, administrative, and nursing reports) since Monitoring Team's last visit, with follow-up evidence of completion of recommendations; o Corrective actions related to Mortality Reviews (including status reports on previous recommendations made prior to last Monitoring Team visit which had follow-up closure or action steps completed); o Notes and orders for any DNRs and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of death reports (clinical/administrative) that remain incomplete/outstanding; o For each PCP, two most recently completed annual medical assessments and physical examinations and prior annual assessment and examination for following individuals: Individual #229, Individual #342, Individual #225, Individual #343, Individual #106, Individual #294, Individual #31, and Individual #194; o Specialty clinic schedule per month for past six months (including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for other reasons than refusals, the list of missed appointments (refusals) for which follow-up appointments were made, the list of missed appointments (non-refusals) for which follow-up appointments were made, the list of refused appointments for which a follow-up visit was completed, the list of missed appointments (other than refusals) for which a follow-up visit was completed, and the list of missed appointments for all reasons still outstanding; o List of all outside consultations for medical purposes for the past six months, categorized by specialty including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for other reasons than refusals, the list of missed appointments (refusals) for which follow-up appointments were made, the list of missed appointments (non-refusals) for which follow–up appointments were made, the list of refused appointments for which a follow-up visit was completed, the list of missed appointments (other than refusals) for which a follow-up visit was completed, and the list of missed appointments for all reasons still pending; o List of individuals: a) with tracheostomies, b) with fractures, date of fracture, type of fracture (i.e., compound, simple, stress, etc.), bone fractured (location), c) with injuries requiring visit to ER or hospitalization since the last onsite review, d) with pica or ingesting inedible object, date of ingestion, object/liquid ingested, whether taken to ER or hospitalized, since the last onsite review; o Policies or procedures for medical screening and routine evaluations; o For those over 50, date of last colonoscopy, identification of reason for colonoscopy (i.e.,

	preventive versus evaluation of active problem), with reason if not up-to-date; o For those women over 40, date of last mammogram and reason listed if not up-to-date (i.e., guardian refusal, etc.); o List of all women age 40 or greater with date of birth; o List of all individuals age 50 or greater, with date of birth; o Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person (include calcium, Vitamin D, IV bisphosphonate, etc.), date of last Dual-energy x-ray absorptiometry (DEXA) scan or statement if not completed; o For men with diagnosis of osteopenia/osteoporosis, copy of any lab work testing for secondary causes (from current active record), other information indicating cause (i.e., specific medications, etc.) of osteopenia/osteoporosis; o For women with diagnosis of osteopenia/osteoporosis, and premenopausal, copy of any lab work testing secondary causes (from current active record), other information indicating cause (i.e., specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake and Vitamin D intake (i.e., based on diet, average percentage of meal ingestion, feeding formula, etc.); o For individuals with Down's syndrome, date of last thyroid test; o For those going to the ER and not hospitalized, copy of IPN from start of signs/symptoms to transfer to ER, ER report, discharge orders from ER and copy of Facility record orders, IPN/Infirmary progress notes, follow-up to any recommendations, for five most recent ER visits at least 30 days prior to the Monitoring Team's visit (in order to allow completion of recommendations): Individual #304, Individual #79, Individual #272, Individual #102, and Individual #147; o For those admitted to hospital, copy of IPN from start of signs/symptoms to transfer to ER, ER note, hospital admission history and physical, discharge summary, copy of discharge orders/recommendations from hospital, and copy of Facility chart orders, IPN/Infirmary progress notes, and follow-up for any hospital discharge orders and recommendations, five most recent hospitalizations that have returned for at least 30 days (in order to allow completion of recommendations): Individual #99, Individual #191, Individual #130, Individual #366, and Individual #252; o For these same five most recent hospitalizations that have been completed, copy of Hospital Liaison Nurse documentation of hospitalization; o Length of stay for Infirmary admissions for past six months, if applicable; o Infectious disease data per quarter by category of infection last two quarters; o Summary report or trend analysis of infectious disease/communicable disease last two quarters; o Avatar pneumonia tracking forms/ pneumonia data from Avatar database for past six months; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth, type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study;

	○ Absolute numbers of new cases (prior year, by month) for the following: a) pneumonia, b) decubitus ulcers, c) UTIs, and d) bowel obstructions; ○ Individuals' names, dates of diagnosis, specific diagnoses (e.g., type of cancer, type of sepsis) for past year for individuals who have been newly diagnosed with: a) malignancy, b) cardiovascular disease, c) diabetes mellitus, d) sepsis, e) bowel obstruction or bowel perforation, and f) pneumonia; ○ List of individuals who have diagnosis of constipation or who are receiving anti-constipation medication at least weekly; ○ All policies and procedures related to seizure management; ○ A list of individuals being treated for seizure disorders, including name of individual, residence, diagnosis (i.e., type of seizure), medication regimen; ○ List of those with status epilepticus since the last monitoring visit; ○ List of seizure medications per individual for diagnosis of seizure disorder; ○ List of those going to ER for uncontrolled/prolonged/new onset seizure since last Monitoring Team visit; ○ List of individuals with refractory seizure disorder; ○ List of individuals with refractory seizure disorder who are being evaluated for Vagal Nerve Stimulator (VNS) placement and the stage of evaluation; ○ Numbers and percentage of individuals with diagnosis of seizure disorder on zero, one, two, three, four, and five antiepileptic drugs (AEDs); ○ Numbers and percentages of persons on older AEDs (i.e., Phenobarbital, Dilantin, Mysoline, and Felbamate); ○ For following individuals most recently sent to the ER/hospital for acute respiratory distress, evaluations/procedures completed for dysphagia and GERD (including dates, brief findings, and copy of supporting documentation): Individual #43, Individual #319, Individual #179, Individual #252, Individual #340, Individual #183, and Individual #194; ○ Copy of most current Medical Department policy and procedure manual; ○ For morning medical meetings for the week prior to the Monitoring Team visit, a copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports; ○ Dates of last two completed annual medical assessments and annual physical examinations for all individuals. ○ Dates of last two completed quarterly medical reviews/IPN completed for all individuals. ○ Number of individuals with a diagnosis of seizure disorder on no antiepileptic medications; ○ Number of individuals with VNS in place, date of placement, date of replacement, if applicable; ○ A copy of the most recently completed annual nutritional assessments for the following individuals with osteoporosis: Individual #242, Individual #343, Individual #31, Individual #79, Individual #342, Individual #273, Individual #22, Individual #240, and Individual #68; ○ For the last five individuals to whom pre-treatment sedation was administered for a medical procedure, all information related to medical pre-treatment sedation used,

	including consents, Human Rights Committee (HRC) approval, relevant assessments, ISP entries, any general discussion record, action plan, and IPN entries. Information submitted for following individuals: Individual #147, Individual #311, Individual #67, Individual #65, and Individual #56; o Ten most recent PNMT recommendations for which physician orders were written based on those recommendations; o ISPA addressing refused medical appointments for the time period 15 to 45 days prior to the Monitoring Team visit; o List of missed medical appointments with reasons past six months; o Presentation Book for Section L; o DADS Preventive Health Care Guidelines, SSLCs, dated August 30, 2011; o For women age 21 to 65, list of individuals with date of last pelvic exam (including whether attempted but unsuccessful), date of last pap smear with determination of adequate reading, sufficient sample, etc., (including whether attempted but unsuccessful), if pelvic not done, the reason/indication, and if pap smear not done including the reason/indication. For those with a history of hysterectomy, list of the reasons for the hysterectomy; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor survey/review, and whether any inter-reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process: list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, the frequency of the data collection; o For each of the following individuals, copies from the active record: most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPN, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries for past one year, ER reports for past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent ISP and subsequent addendums, most recent Behavior Support Plan (BSP), past 3 medical quarterly reviews: Individual #8, Individual #130, Individual #333, Individual #15, Individual #101, and Individual #335; and o Minutes of the medical morning meeting with handouts during the Monitoring Team visit. ▪ **Interviews with**: o Ingela Danielsson-Sanden, MD Medical Director; o Norma Brown, MD, Staff Physician; o Aysun Alagoz, MD, Staff Physician; o Michael Perez, DO, Staff Physician; o Kusumakar Sooda, MD, Staff Physician; o Laura Ramon, RN, Medical Program Compliance Nurse; o Cynthia Velasquez, Quality Assurance Director; and

	○ Jennifer Graves, RN, QA Department. ▪ **Observations of**: ○ Integrated Clinical Services Meeting, on 4/1/14, 4/2/14, and 4/3/14; and ○ Individual #101, Individual #260, Individual #340, Individual #366, Individual #57, Individual #93, Individual #160, Individual #270, Individual #307, Individual #16, Individual #266, Individual #276, Individual #239, Individual #274, Individual #130, Individual #350, Individual #301, Individual #201, Individual #247, Individual #314, Individual #122, Individual #215, Individual #232, Individual #15, Individual #21, Individual #22, Individual #212, Individual #124, Individual #280, Individual #272, Individual #23, Individual #25, Individual #292, Individual #327, Individual #229, Individual #334, Individual #205, Individual #24, Individual #207, Individual #28, Individual #134, Individual #319, Individual #222, Individual #299, Individual #50, Individual #113, Individual #163, Individual #181, Individual #240, Individual #290, Individual #77, Individual #79, Individual #126, Individual #161, Individual #278, Individual #244, Individual #154, Individual #342, Individual #104, Individual #70, Individual #150, Individual #305, Individual #250, Individual #146, Individual #328, Individual #324, Individual #293, Individual #68, Individual #32, Individual #245, Individual #128, Individual #335, Individual #333, Individual #179, Individual #223, and Individual #8.
	Facility Self-Assessment: For Section L, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: the external and internal medical provider quality assurance audits, external and internal medical management audits, various Medical Department internal audits (as described with regard to Sections H, and L.3). ○ These monitoring/audit tools included many indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators that are relevant to making compliance determinations. The Monitoring Team noted that the degree of self-assessment surveillance was extensive. Matching the self-assessment process to areas the Monitoring Team measures will identify areas of need that have not been measured. ○ The monitoring tools included adequate methodologies, such as record reviews. ○ The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. ○ Some of the monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. Others were not reviewed, because they were not submitted.

	○ The following staff/positions were responsible for completing the audit tools: Medical Program Compliance Nurse. ▪ The Facility used some other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached, such as databases recording timely completion of annual medical assessments, and timely completion of preventive tests and procedures. The quality of the data maintained in the databases was noted to be complete and accurate. There were very few instances of database entry errors. ▪ Examples of data the Facility was not collecting/using regarding its self-assessment were the quality of the family history as part of the annual medical assessment, quality of the open record review, whether recommendations of the open record review were included in the post-hospital ISPA, and whether the IDTs used them to develop preventive measures. ▪ The Facility presented some data in a meaningful/useful way, but some concerns were noted. Specifically, the Facility's Self-Assessment: ○ Presented findings consistently based on specific, measurable indicators. ○ Did not consistently measure the quality as well as presence of items. ▪ The Facility rated itself as being in noncompliance with Sections L.1, L.2, L.3, and L.4. This was consistent with the Monitoring Team's findings. ▪ The Facility data did not identify additional areas in need of improvement. However, the many current audits and database systems will need to be in place for sufficient time to allow the Facility to determine trend analysis and develop action plans based on areas identified as needing improvement.
	Summary of Monitor's Assessment: The Medical Department had made some good progress. The data the Medical Department produced appeared to be complete, accurate, and reliable. The pneumonia data was no longer confusing, but appeared to be based on one accurate database for all requests. Preventive care tests and procedures appeared to be tracked to completion. There had been a reduction in the number of hospitalizations in recent months. The implementation of the "unstable vital sign protocol" might have had an impact on reducing the hospitalization rate. The Integrated Clinical Services Team meeting appeared to continue to grow and participants reviewed acute health status change of individuals that resided at CCSSLC, and tracked individuals admitted to area hospitals. To allow tracking of timely follow-up to concerns the group identified, the goal should be to have the final Integrated Clinical Services Team meeting minutes available the next day, but currently a system was not in place to allow this to occur. The quality of the quarterly medical reviews had improved. However, ensuring annual medical assessments and quarterly medical reviews were completed in a timely manner was a continuing challenge. Other challenges related to the clinical care of individuals included, for example: ▪ With regard to identifying secondary causes for osteoporosis for men, information the Facility submitted suggested significant need for treatment of testosterone levels and Vitamin D levels. However, the testing done to make this determination did not appear to have been synchronized

	with the annual medical assessments, or at other times when blood work was drawn routinely. That the lab testing occurred recently appeared to indicate testing was done to fulfill the Monitoring Team's request for information. The number of abnormal findings indicated that treatment had not been optimized for osteoporosis/osteopenia in a significant number of individuals. ▪ Similarly for women with osteoporosis/osteopenia, lab tests for twenty-nine of 69 women (42%) indicated abnormally low Vitamin D levels. All lab tests results were from February 2014, and appeared to be a response to the Monitoring Team's request for information. The number of abnormal findings also indicated that treatment has not been optimized for osteoporosis/osteopenia in a significant number of individuals. ▪ The Facility submitted evaluations for dysphagia and gastroesophageal reflux disease (GERD) for seven individuals that had acute respiratory distress requiring an ER visit or hospitalization. Review of this information suggested the need for further review to ensure thorough evaluations of GERD in those with acute respiratory distress. ▪ In recent months, four individuals had sustained hip fractures. This should have resulted in an interdisciplinary review and analysis to determine potential common causes and to identify any necessary corrective actions. For 10 of the 22 individuals with Do Not Resuscitate (DNR) orders in place, clinical justification had not been established. This placed individuals at risk of not receiving appropriate treatment. The Facility had not held Ethics Committee meetings in the months since the Monitoring Team's last review. The quality of the death reviews needed to be critically analyzed, with development of criteria/events that would then trigger a root cause analysis. Much can be learned from a critical review of events surrounding a death, with the goal of implementing systems to prevent recurrence, protect the individuals form harm, and provide the needed support to staff. Without such a rigorous system, the death review process will represent a missed opportunity for learning and improvement.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the	Given that Section L.1 of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, and Do Not Resuscitate (DNR) Orders. <u>Staffing and Administration</u> For the census of 236 as of 2/21/14, there were four PCPs and a Medical Director responsible for this population. The Medical Director had no caseload. The four PCPs had caseloads ranging from 56 to 61. There was no vacancy in the Medical Department.	Noncompliance

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	individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	A list was submitted indicating those members of the Medical Department that remained current in CPR certification. Five of five (100%) physicians (Medical Director and PCPs) were current in CPR. Of the five physicians in the Medical Department, a list of CME credits was submitted for two physicians. Three physicians did not participate in CME activity in the prior six months. ▪ CME credits for the two PCPs varied from eight to 13 hours. ▪ The topics that were covered included: communication skills, seizure updates, vagus nerve stimulation, seizure clusters, depression, chronic pain management, dementia, ovarian cancer, and treatment of visual hallucinations. ▪ The majority of the topics that were covered included areas of importance to primary care and the individuals residing at CCSSLC. ▪ There were no topics specific to developmental disabilities. <u>Physician and other Departmental Participation In Team Process</u> ▪ For the three morning medical meetings observed, there was a signed attendance roster in three of three meetings. ▪ For the three morning medical meetings observed, there were two hospitalizations (i.e., Individual #252 and Individual #311), and eight ongoing or new admissions to the Infirmary (i.e., Individual #8, Individual #24, Individual #56, Individual #333, Individual #301, Individual #179, Individual #128, and Individual #223). Based on the Monitoring Team's observations and review of documentation: ▪ **Assignment of follow-up to meeting participant:** There was one clinical question raised/identified needing closure. It was followed by assignment of the concern for further review by one or more morning medical meeting attendees concerning steps to be taken to prevent a recurrence. ▪ **Assignment of open book/record review:** There was one assignment of an open record review for one hospitalization/ER visit/Infirmary admission. ▪ For **previously assigned open book/chart reviews**, two were presented during the three morning meetings. The reviews appeared thorough, and provided a review of several areas of care. One review included several recommendations/findings that were clinically applicable to the individual concerning pain management. They focused on recognizing subtle changes/differences in behavior applicable to determining discomfort as opposed to behavior due to other causes. ▪ **Closure discussions**: There were three prior concerns with assignments for follow-up that were presented at the medical morning meetings. ▪ **Requested follow-up ISPA reviewed:** There were zero brief summaries of ISPAs that the ICST had assigned to IDTs to respond to concerns identified. One ISPA was submitted for review, but had incorrect formatting and was to be presented once corrected. ▪ **Infection control updates:** During the three medical morning meetings, there were two infection control updates presented. ▪ **Summaries of completed consultations:** During the three medical morning meetings, there were 10 summaries presented of completed consultations from the prior day.	

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		▪ **Dental Department updates**: The Dental Department provided brief updates/information during one of three medical morning meetings. ▪ **PT/OT/Speech Therapy (ST) and PNMT updates:** The Habilitation Therapies Department and PNMT presented updates during zero of three medical morning meetings. PNMT was not scheduled to present during these three morning medical meetings (i.e., the PNMT was scheduled to report on Friday of each week). ▪ **Skin integrity updates:** Skin integrity reports/updates were provided at zero of three medical morning meetings. ▪ **Discussion of significant weight change:** There was a discussion of individuals with significant weight loss or gain at zero of three medical morning meetings. ▪ **Hospital Liaison Nurse updates:** The Hospital Nurse Liaison reported an update for two of two hospitalizations during the observed meetings, and reported at three of three morning medical meetings. ▪ **On-call PCP participation:** For the three morning medical meetings observed, the on-call PCP (from the prior evening) participated in presenting the cases in one of three meetings. In two of three meetings, this was not applicable due to there not being any on-call issues to discuss. ▪ **Campus 24-hour medical log report:** The Campus 24-hour medical log report was reviewed at three of three morning medical meetings. The strengths noted at the medical morning meeting included the following: ▪ There was detailed clinical discussion including participation from several departments. The attending physicians provided background information, followed by a discussion of immediate actions to be taken based on updated information. Critical information concerning physical findings, test results, and treatment options were part of the discussions. ▪ The open record reviews appeared to reflect in-depth quality review of events and care prior to the acute illness/change of status. ▪ The morning medical meeting appeared to be well attended. Weakness and concerns included: ▪ The ISPA did not appear to reflect the findings of the open record reviews. The information learned through the open record reviews would be helpful in guiding the IDTs in developing preventive strategies post hospitalization. ▪ There appeared to be a delay in providing closure to several concerns identified at the morning provider meeting. Facility Administration is encouraged to review this area needing improvement and several departments' cooperation (i.e., residential, QIDP, etc.) should be required to improve the efficiency and effectiveness of the morning meeting. ▪ The length of time from each ICST meeting to the final minutes was greater than one week. The meeting was taped, and transcription was then sent off campus. On return, revisions then occurred. The final product also would benefit from more succinct summarization of the many integrated clinical discussions. The transcription recorded every word, but there needed to be a review of the editing process. Overall, this entire process needed review, as minutes should be available the next	

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		business day as a reference, if needed. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted. A total of 250 individuals were listed. Ten individuals had been new admissions in the prior year and were omitted, because dates of two annual assessments were not available. The remaining 240 individuals were reviewed. There was no information or misinformation suggesting a typographical error or data entry error. ▪ Of these, 170 of 240 (71%) of the recent annual medical assessments were completed within 365 days of the prior assessment. This same list was reviewed to determine whether the annual medical assessments and physical exams had been completed in the 365 days prior to the Monitoring Team's visit, with a cut off date of 3/1/14 to allow for data entry. Of the 250, three individuals were deceased and were removed from the list. Two hundred three of 247 (82%) had been completed in the 365 days prior to 3/1/14. For each PCP, the two most recently completed annual medical assessments and physical examinations and prior annual medical assessments and physical examinations were submitted for review. Timeliness was determined if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. For the eight individuals, compliance was seven of eight (88%). ▪ For the eight most recent annual medical assessments, there was an interval history included as part of the document in eight of eight (100%) reviews. It was noted that for three of the annual assessments, the interval history was brief. The Facility should review the quality of the components of the annual medical assessment. ▪ For the eight most recent annual medical assessments, the major active problems listed had plans of care addressing each of the significant current diagnoses in eight of eight (100%) assessments. ▪ For the eight most recent annual medical assessment, seven of eight (88%) addressed smoking history. ▪ Family history was adequate/helpful in zero of eight (0%). For four of eight, there was no information available. For four of eight, there was incomplete information. ▪ A discussion of readiness/requirements for transition to the community was included in eight of eight (100%). As part of the monitoring review process, the Monitoring Team selected the medical records of six individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The records selected were based on identifying individuals with various diagnoses/health care issues, and selecting a sample of individuals with multiple high-risk areas (e.g., aspiration, GERD, skin breakdown, cardiac issues, etc.). This sample was selected to allow the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. Documents reviewed included the preventive care flow sheet, physician orders for the prior one year, IPNs	

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		for the prior one year, the most recent three quarterly medical reviews, most recent BSP, last annual ISP and subsequent addendums, labs, x-rays/CT scans, MRI scans, ultrasound scans, other radiographic test results for the prior one year, the IRRF, the most recent health care management plan/risk action plan/integrated health care plan, the most recent annual medical assessment and physical exam, DNR forms if applicable, the most recent nursing assessment, any hospital discharge summary for the past year, ER visits for the past year, and any consult reports and procedure reports from the past year. Each aspect is discussed as the relevant preventive or routine care topic is discussed. From six medical records reviewed: ▪ Six of six (100%) annual medical assessments had been completed in the prior 365 days. ▪ Active problem lists appeared to be thorough in five of six (83%). ▪ Six of six (100%) included a smoking history and/or substance abuse history. ▪ A quality family history was documented or the individual was adopted and there was no ability to determine family history in two of six (33%) charts. ▪ Six of six (100%) had information discussing requirements for transition. These six medical records also were reviewed to determine whether the physician IPN notes used the SOAP format for acute illness/injury documentation. In five of six, PCP IPNs could be found documenting acute illness or injury. ▪ In five of five (100%), the SOAP format was used. ▪ In five of five (100%), the SOAP IPN included the date. ▪ In five of five (100%), the SOAP IPN included the time. ▪ In five of five (100%), the SOAP IPN recorded vital signs or referenced vital signs from a prior note. <u>Quarterly Medical Reviews</u> The Medical Department provided a list of quarterly medical reviews (and annuals if completed in a month in which a quarterly was due) that were completed each quarter for all individuals. Information for 239 individuals was provided. For each month, the list of individuals for which quarterlies were due was provided, along with the date completed. If a quarterly was overdue or not completed, this was listed on the submitted information. The following provides the number of individuals per month in which a quarterly was due, and the number of quarterlies completed:	

Month	Number of Individuals for Whom Quarterly Medical Reviews Were Due	Number of Quarterly Medical Reviews Completed on Time	Percentage of Quarterly Medical Reviews Completed on Time
August 2013	89	65	73%
September 2013	71	29	41%
October 2013	77	44	57%
November 2013	91	59	65%

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December 2013	69	35	51%
January 2014	76	56	74%
February 2014	91	55	60%
Total timely reviews	**564**	**343**	**61%**

Contents of 26 quarterly medical reviews were reviewed for completeness:

- A template format was used/completed in 26 of 26 quarterly medical reviews.
- Twenty-six of 26 (100%) included the date of the quarterly medical review completion.
- Major diagnoses and/or new diagnoses were listed in 25 of 26 (96%) medical quarterly reviews.
- The last three monthly weights or equivalent information were recorded in 26 of 26 (100%) medical quarterly reviews.
- There were brief comments/entries listing numbers of seizures per quarter (if applicable) in 15 of 15 (100%) medical quarterly reviews.
- There was documentation of changes in medication (when applicable) in 19 of 19 (100%) medical quarterly reviews.
- Important/abnormal labs and drug levels/radiographic test results were documented (when applicable) in 21 of 21 (100%) medical quarterly reviews.
- Six individuals had documentation of an ER visit. Six of six (100%) included reasons for the ER visit.
- Four individuals had documentation of hospitalization. Four of four (100%) included reasons for the hospitalization.
- Thirteen of 13 (100%) individuals had documentation of consultations completed, listing the specialty.

Access to Specialists

Based on data the Facility submitted, the following chart indicates the off-site appointments scheduled, the off-site appointments completed, follow-up appointments scheduled, follow-up appointments completed, and pending appointments. Information provided was for appointments beginning in August 2013 and ending in January 2014.

Specialty	Initial Appointment Scheduled	Initial Appointment Completed	Number of Appointments Rescheduled	Follow-up Initial Appointment Completed	Pending	Completion Ratio
Dermatology	19	17	1	1	0	18/19
Cardiology	61	46	13	11	2	57/61
Nephrology	12	9	3	3	0	12/12
Ear Nose Throat (ENT)	60	43	15	14	1	57/60
Endocrinology	1	1	0	0	0	1/1
Gastroenterology	35	30	4	2	2	32/35

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(GI)							
Hematology	0	0	0	0	0	0
Neurology	9	6	3	3	0	9/9
Ophthalmic	165	97	61	25	36	122/165
Podiatry	55	41	10	8	2	49/55
Pulmonary	15	11	2	2	0	13/15
Oral Surgery	19	14	5	5	0	19/19
Rheumatology	1	1	0	0	0	1/1
Gynecology (GYN)	12	7	5	2	3	9/12
Orthopedic	27	20	6	5	1	25/27
Urology	47	30	15	9	6	39/47
Wound Care	0	0	0	0	0	0
Total	**538**	**373/538 (69%)**		**90**	**53/538 (10%)**	**463/538 (86%)**

No information was available to determine which appointments had orders not to be rescheduled (i.e., condition resolved, etc.), or other reason (e.g., individual moved to the community). Completed and pending scheduled appointments totaled 96 percent of off-site appointments.

Onsite, specialty clinics were held to meet the needs of the individuals from 8/21/13 through 1/15/14. The following chart provides details of these specialty clinics:

Specialty	Date of Clinic	Appointments Scheduled	Appointments Completed	Follow-up to Prior Appointment Scheduled or Other Documentation
Orthopedics	8/21/13	14	14	
Neurology	8/24/13	19	19	
GYN	9/23/13	6	6	
GYN	9/24/13	7	7	
GYN	9/25/13	8	8	
GYN	9/26/13	11	11	
GYN	9/27/13	7	6	1
GYN	9/30/13	12	10	2
GYN	10/1/13	12	12	
GYN	10/2/13	10	10	
GYN	10/3/13	10	9	1
GYN	10/4/13	3	1	1
GYN	10/15/13	1	1	

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GYN	10/16/13	1	0	
Orthopedic	1/15/14	11	11	
Total		**132**	**125 (95%)**	

The Facility indicated there were no on-campus appointments for November 2013 and December 2013.

The Medical Department submitted a list of all off campus and on campus medical appointments that had been missed for all causes. The following is the number of missed appointments per month:

Month	Number of Missed Off-Site Appointments	Number of Missed Onsite Appointments	Month	Number of Missed Off-Site Appointments	Number of Missed Onsite Appointments
August 2013	29	0	November 2013	29	0
September 2013	26	3	December 2013	27	0
October 2013	25	3	January 2014	28	0

The following lists the total number of off-campus missed appointments due to the most common reasons:

Reason for Missed Appointment	Number of Missed Appointments
Specialist office canceled	45
Cancelled by PCP	31
Refused	42
Staff issues	5
No transportation	4
Administrative reasons - paperwork not prepared, schedule conflict, etc.	13
Other	26

The Facility where appropriate, appeared to have a system of rescheduling non-refused missed appointments. As mentioned in the above information, the completion rate was 86% when follow-up appointments were completed and another 10% were pending completion at a future date.

It was noted in a document entitled: "CAP Tracking" that training was to be provided to IDTs concerning refusal of appointments. This was to occur by 3/7/14.

The quality of the consultation referrals is reviewed as part of the peer review process. This is discussed in further detail with regard to Sections L.2 and L.3. In addition, the Monitoring Team's findings with regard to the follow-up on consultations are discussed with regard to Section G.2.

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		Preventive Care ▪ Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in six of six (100%) records reviewed. ▪ Preventive care flow sheets were updated at the time of the most recent annual medical assessment in five of six (83%) records reviewed. ▪ Current vision screening was documented within the prior 12 months in five of six (83%) records reviewed, and in six of six (100%) within the prior 24 months. ▪ Audiological screening occurred in six of six (100%) records reviewed in the prior three years. ▪ Documentation was clear whether the influenza vaccination had been administered to six of six (100%) individuals. ▪ Whether the individual needed to receive varicella vaccine (i.e., depending on birth date and immunity status), and whether it was given if indicated was recorded in six of the six (100%) active records reviewed. ▪ Whether the individual needed to receive a hepatitis B vaccine (i.e., depending on immunity status, carrier state, etc.) and whether the series was completed if indicated (or being tracked for completion) was recorded in six of the six (100%) active records reviewed. ▪ A Tetanus, Diphtheria and Pertussis (Tdap) Vaccine had been given to five of six (83%) individuals. ▪ A pneumococcal vaccination had been given to six of six (100%) individuals. ▪ For individuals age 60 or over, a zoster vaccine had been given to one of one (100%) individual. A list was submitted indicating women residing at CCSSLC who were over the age of 40, along with the date of last mammogram, and the reason, if it was not done or was outdated. The DADS SSLCs policy "Preventive Health Care Guidelines," dated 8/30/11 was to be followed. A total of 93 women were identified as being over the age of 40. Of these, there were two women aged 70 or greater. These two individuals were not included in the compliance analysis. Of the 91 women between the ages of 40 and 70, 15 had reasons not to have a mammogram (i.e., guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 76 women, 70 had mammograms within the year prior to the cut off date of 2/1/14. This was a compliance rate of 70 out of 76 (92%). From the sample of six medical records reviews, there were two females between the ages of 40 and 70. Of these, one female was eligible for a yearly mammogram (i.e., no contraindication or reason for not completing a mammogram). One of one (100%) was up-to-date on mammogram testing. The Facility provided a list of women ages 21 to 65 with the date of most recent pap smear, pelvic exam, results of pap smear, and whether the individual had a hysterectomy in the past. Ninety-two names were listed. Of these, three individuals had refused, and one had an insufficient pap smear. Eighty-eight of 92 (96%) had an adequate pap smear within the prior three years or results were pending. Eighty-eight of 92 (96%) included a pelvic exam. For one, the information was not available as to whether a pelvic exam was completed. Five women had a hysterectomy in the past.	

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		From the sample of six active records reviewed, there were two females between the ages of 21 and 65. Two of two (100%) females had documentation of cervical cancer screening within the prior three to five years. The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, including the reason for the colonoscopy (i.e., screen or diagnostic testing for signs and symptoms). A total of 124 names were submitted. Of these, four were over the age of 75. No incomplete data or data entry irregularities required removal of any individuals from the list. As it takes time to schedule appointments/procedures and have IDTs discuss potential complications related to the preparation involved, one individual at age 50 (who had not completed a colonoscopy) was removed from the list. Additionally, seven individuals had clinical contraindications or family/guardian refusals of consent. Thirty-three individuals had completed a colonoscopy in the prior 10 years for non-screening reasons and were removed from the list of individuals for whom screening colonoscopy was completed. Therefore, the eligible population was 79 individuals. Of these, 78 (99%) completed a colonoscopy within the prior 10 years, and/or had alternate testing considered acceptable as clinical equivalents. Of the six active records reviewed, there were four individuals from the age of 50 to 75. Four of four (100%) had a colonoscopy completed in the past 10 years. A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. The date and result of the last DEXA scan was requested. Identification of the medications and dosages of the medications treating these diagnoses also was requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T-score usually would be an important aspect of the work-up provided through a DEXA scan. Additionally, based on the T-score, treatment would be ordered to optimally treat the individual. Follow-up DEXAs to determine T-scores are indicated at intervals (every two to three years) to determine effectiveness of treatment. Two separate charts of information were submitted. A total of 125 individuals with a diagnosis of osteopenia or osteoporosis were listed. Of these, 119 had the date of the most recent DEXA scan submitted, as well as the T-score. Of the 125 individuals reviewed, three had T-scores that were interpreted as normal. Seven had no record of DEXA scan completion or results, and the criteria for the diagnosis were not determined in the submitted information. The remaining 115 individuals had either osteoporosis or osteopenia. ▪ One hundred eleven of the 114 (97%) DEXA scans were considered current (i.e., completed within the prior three years). ▪ The percentage of those prescribed a bisphosphonate or alternative medication to treat or prevent osteoporosis could not be determined, because one of the two tables did not include this information. ▪ One hundred six of 115 were treated with calcium supplementation. ▪ One hundred six of 115 were treated with Vitamin D supplementation. For men with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. Forty-eight	

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		men were determined to have osteoporosis or osteopenia. The following lists the compliance with several recommended tests, based on submitted information: ▪ Forty-four of 48 (92%) had a testosterone level recorded. Twenty of 44 (45%) indicated abnormally high or low values. ▪ Forty-seven of 48 (98%) had renal function recorded. ▪ Forty-eight of 48 (100%) had liver function recorded. ▪ Forty-five of 48 (94%) had thyroid function recorded, ▪ Forty-seven of 48 (98%) had CBC results recorded. ▪ Forty-seven of 48 (98%) had a calcium level recorded. ▪ Forty-six of 48 (96%) had a Vitamin D level recorded. Sixteen of 46 (35%) had abnormally low levels. The information suggested significant need for treatment of testosterone levels and Vitamin D levels. It was noted that 47 of 48 lab tests submitted occurred in February 2014. They did not appear to be synchronized with the annual medical assessment, or at other times when blood work was drawn routinely. That the lab testing occurred recently appeared to indicate testing was done to fulfill the Monitoring Team's request for information, rather than to indicate that these lab tests were ordered as part of a systems approach to monitor treatment of osteopenia/osteoporosis. The number of abnormal findings indicated that treatment had not been optimized for osteoporosis/osteopenia in a significant number of individuals. For women with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. Sixty-nine women were determined to have osteoporosis or osteopenia. The following lists the compliance with several recommended tests, based on submitted information: ▪ Sixty-eight of 69 (99%) had renal function recorded. ▪ Sixty-eight of 69 (99%) had liver function recorded. ▪ Sixty-six of 69 (96%) had thyroid function recorded. ▪ Sixty-eight of 69 (99%) had a CBC recorded. ▪ Sixty-eight of 69 (99%) had a calcium level recorded. ▪ Sixty-nine of 69 (100%) had a Vitamin D level recorded. Twenty-nine of 69 (42%) indicated abnormally low Vitamin D levels. All lab tests results were from February 2014, and appeared to be a response to the Monitoring Team's request for information, rather than to indicate that these lab tests were ordered as part of a systems approach to monitor treatment of osteopenia/osteoporosis. The number of abnormal findings indicated that treatment has not been optimized for osteoporosis/osteopenia in a significant number of individuals. Nine Nutrition Services Comprehensive Assessments were reviewed for content concerning calculation of daily calcium and Vitamin D in the diet and supplements: ▪ Nine of nine included the daily amount of calcium available in the offered diet. ▪ Zero of nine included the daily amount of Vitamin D in the offered diet. Although the amount of Vitamin D in an offered diet might not be readily available, the amount of Vitamin D in formula	

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		feedings would be available. ▪ Zero of nine included the amount of calcium in the daily multivitamin/mineral supplement when prescribed. ▪ Zero of nine included the amount of Vitamin D in the daily multivitamin/mineral supplement when prescribed. ▪ Zero of nine included the total daily supplementation of calcium other than in a multivitamin/mineral supplement. Although supplementation was listed, the information did not provide the total amount of calcium through supplementation. ▪ Zero of nine included the total daily supplementation of Vitamin D other than in a multivitamin/mineral supplement. Although supplementation was listed, the information did not provide the total amount of Vitamin D through supplementation. ▪ Zero of nine calculated the total daily intake of calcium in the diet and supplements. ▪ Zero of nine calculated the total daily intake of Vitamin D in the diet and supplements. The assessment was helpful to the PCPs in providing the amount of calcium provided/offered to the individual through the diet. The PCP would have to use other sources of information to determine total daily intake of calcium and Vitamin D, which could then be used in determining the amount of supplementation of these nutrients to meet daily requirements. From the sample of six medical records reviewed, four had a diagnosis of osteopenia or osteoporosis. Three of the four had completed a DEXA scan. Three of three of these DEXA scans were completed in the prior three years. ▪ Of these, three of three had a DEXA scan/T-score recorded. ▪ Of these, three of three (100%) had a T-score consistent with the diagnosis of osteoporosis or osteopenia. ▪ Of these three, three (100%) had been prescribed supplemental calcium and Vitamin D. ▪ Of these, three of three (100%) had a bisphosphonate ordered. *Down Syndrome and Hypothyroidism* A list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of 12 individuals were identified with a diagnosis of Down syndrome. Twelve of 12 (100%) had a thyroid test completed within the prior 12 months. <u>Acute and Emergency Care</u> The Facility provided documentation for Emergency Room visits from September 2013 through February 2014. The following table lists the analysis of this raw data by month, the number of ER visits for the month, and the most frequent/common categories of diagnosis for the visits. The Medical Department provided this information: |	# of ER Visits								
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Month		Trauma	GI	Respiratory	Neurology	Infection	Cardiology	Bleeding	Other
September 2013	1	0	0	0	0	0	0	0	1
October 2013	1	1	0	0	0	0	0	0	0
November 2013	3	1	1	0	0	0	0	0	1
December 2013	4	0	2	0	0	0	0	0	1
January 2014	2	1	0	0	0	0	0	0	1
February 2014	0	0	0	0	0	0	0	0	0
Total	11	3	3	0	0	0	0	0	4

This information indicated there were few ER visits in the prior six months. It is recommended that the Medical Department review this information for completeness and accuracy of data. That there were no ER visits for an infectious etiology (i.e., UTI, cellulitis, etc.), no ER visits for respiratory conditions, and only three for gastrointestinal concerns (i.e., ileus, vomiting, etc.) might have reflected the impact of the protocol for transferring individuals with unstable vital signs to the Infirmary, or might have indicated under-reporting. The Medical Department should review the data to verify or amend this information.

The active record was reviewed for five individuals who most recently had gone to the ER and returned. These individuals are listed in the documents reviewed section. The following summarizes the results of this review:

- Information was submitted indicating that the ER was notified prior to the arrival of the individual with medical background information provided for five of five (100%) records.
- Prior to the transfer to the ER, a PCP was onsite for one of these transfers. In one of one (100%) record, the PCP had written an IPN that included the date and time.
- For one of one PCP transfer IPN, reason for the transfer was documented.
- In one of one, the SOAP format was utilized.
- A copy of the ER report/discharge instructions/follow-up information was available in five of five (100%).
- Of the five ER visits, diagnostic categories included: gastroenterology concern (three), trauma (one), and genitourinary (GU) concern (one).
- When the individual returned to the Facility after evaluation at the ER, five of five (100%) active records had a PCP IPN.
- Five of five (100%) post-ER visit PCP IPNs included date and time.
- Three of five (60%) post-ER visit PCP IPNs included recording of vital signs in the IPN or were available through a nursing IPN adjacent to the PCP IPN.
- Four of five (80%) post-ER visit PCP IPN utilized a SOAP format.
- A summary of ER information and findings was included in five of five (100%) PCP IPNs.

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- For five of five, treatment was considered timely. There were no perceived delays in care in transferring the individuals to the ER.

The Medical Department provided documentation for hospital admissions from September 2013 through February 2014. The following table lists the analysis of this raw data by month, the number of hospitalizations for the month, and the most frequent/common categories of diagnosis for the admissions.

Month	Number of Admissions	Respiratory	Neurology	GU	GI	Bleeding	Infection	Other
September 2013	19	9	0	0	4	0	1	5
October 2013	6	4	0	1	0	0	0	1
November 2013	10	3	0	3	2	0	1	1
December 2013	8	4	0	0	2	0	0	2
January 2014	7	1	0	0	2	0	2	2
February 2014	6	3	0	0	2	0	1	0
Total	**56**	**24**	**0**	**4**	**12**	**0**	**5**	**11**

Additionally, five active records were reviewed for individuals admitted to the hospital. The following provide the results of this review:

- Five individuals returned to the Facility. Five of five (100%) had PCP IPNs post-hospitalization.
- Of the five post-hospital PCP IPNs submitted, four included vital signs or there was an adjacent nursing IPN with vital signs.
- Five of five (100%) post-hospital PCP IPNs included date and time.
- Four of five (80%) post-hospital PCP IPNs had an adequate summary of hospital events and findings.
- Five of five (100%) post-hospital PCP IPNs used the SOAP format.
- Five of five (100%) active records of the hospitalized individuals included a copy of the hospital admission history and physical.
- Three of five (60%) active records included a copy of the hospital discharge summary.
- Five of five (100%) active records included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary.
- Five of five (100%) included Hospital Liaison Nurse notes for the individuals.
- For four of the five individuals that returned to the Facility, additional PCP IPNs were included as part of the follow-up.

CCSSLC had an Infirmary. Documentation was provided for Infirmary admissions from September 2013 through February 2014. The following lists the month, the number of Infirmary admissions for the month,

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and the most frequent/common category of diagnosis for the admissions. The Medical Department provided this information:

Month	Number of Admissions	Trauma	GI	Respiratory	Infections	Fever	Met/ end	Neurology	Dental/ Post Op	Other
September 2013	10	0	0	3	1	1	0	0	3	2
October 2013	15	0	0	6	1	2	0	0	3	3
November 2013	12	0	1	2	4	1	0	0	2	2
December 2013	11	0	1	2	2	2	0	0	2	2
January 2014	15	0	1	3	1	7	0	0	0	3
February 2014	13	0	0	3	3	1	0	0	1	5
Total	**76**	**0**	**3**	**19**	**12**	**17**	**0**	**0**	**11**	**17**

For those that were discharged from the Infirmary, the length of stay varied as follows:

- The number staying one day or less was 18.
- The number staying two days was 12.
- The number staying three days was five.
- The number staying four days was two.
- The number staying five days was three.
- The number staying six days was four.
- The number staying seven to 10 days was nine.
- The number staying 11 to 20 days was 11.
- The number staying 21 to 30 days was six.
- The number staying 31 to 60 days was two.
- The number staying 61 or more days was four.

Pneumonia

For the time period August 2013 through January 2014, the Facility submitted data concerning pneumonias from the Avatar database. According to this database, there were 31 pneumonias during this time period. Of these 31, three were categorized as aspiration pneumonia. Off-site physicians diagnosed sixteen of these 31 pneumonias. As part of confirmation of the diagnosis of pneumonia, the following information was provided in this database. Thirty-one of 31 had a chest x-ray completed. For 22 of these 31, the chest x-ray confirmed pneumonia. For 16 of the 31, data submitted indicated blood cultures were obtained. Blood cultures were positive in three of 16. In summary, supportive evidence was found for the diagnosis of pneumonia for 23 of 31. According to the database:

- Twelve individuals were taking nutrition by mouth (PO) at the time of the pneumonia. For 12 of 12,

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there was documentation of a therapeutic diet with varying textures and fluid thickenings.

- Nineteen of the 31 individuals had a feeding tube prior to the onset of the pneumonia.
  - Sixteen of the 19 feeding tubes were gastrostomy tubes, one was a gastrojejunostomy tube, and two were jejunostomy tubes.
  - The formula flow rate for those individuals with gastro-jejunostomy tubes and jejunostomy tubes was continuous in one of three. For those with gastrostomy tubes, 10 utilized an intermittent flow rate, five utilized bolus feedings, and one utilized continuous feedings.

The pneumonia incidence per month from the Avatar database was as follows:

Month	Number of Pneumonia Cases	Number of Aspiration Pneumonias	Number of Bacterial Pneumonias	Number of Viral Pneumonias
August 2013	4	0	4	0
September 2013	13	3	8	2
October 2013	4	0	4	0
November 2013	3	0	3	0
December 2013	3	0	2	1
January 2014	4	0	4	0
Total	**31**	**3**	**25**	**3**

All files in which pneumonia data was submitted agreed with the Avatar data for pneumonias. This was an improvement over previous reviews.

The Facility submitted evaluations for dysphagia and GERD for seven individuals that had acute respiratory distress requiring an ER visit or hospitalization. For a dysphagia evaluation, one had a Modified Barium Swallow Study (MBSS) in the record. For a GERD work-up as a potential cause or contributing comorbid condition, one had an esophagoduodenoscopy, none had a gastric emptying study, and none had evaluation with a pH probe in the esophagus. For treatment, three had a fundoplication. Four had a jejunostomy tube, and six had a gastrostomy tube for stomach drainage, for feeding, or had a gastrostomy tube in the past that was replaced with a jejunostomy tube. Seven were prescribed medication for GERD/gastritis. Three had a gastroenterology consult in the prior two years. This information suggested the need for further review to ensure thorough evaluations of GERD in those with acute respiratory distress.

Sepsis

Four individuals were diagnosed with sepsis in the time period from August 1, 2013 through January 2014. The following table provides the breakdown per month:

Month	Number of Sepsis Cases	Month	Number of Sepsis Cases
August 2013	0	November 2013	1
September 2013	1	December 2013	1

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October 2013	0	January 2014	1
Total all months	**4**		

Trauma
From August 2013 through January 2014, there were six individuals referred to the ER and/or admitted to the hospital for trauma.

Month	Number of Injuries	Laceration	Fracture
August 2013	2	1	1
September 2013	1	0	1
October 2013	1	1	0
November 2013	1	0	1
December 2013	0	0	0
January 2014	1	0	1

During the time period from August 2013 through January 2014, nine individuals sustained fractures.

Month	Number of Injuries	Month	Number of Injuries
August 2013	2	September 2013	4
October 2013	0	November 2013	1
December 2013	0	January 2014	2

Five fractures involved the hands, fingers, or toes. Two fractures involved the hip. Two fractures involved the lower leg. More recently, at the time of the Monitoring Team visit, there were two additional individuals with hip fractures admitted to the Infirmary. This number of hip fractures should have resulted in an interdisciplinary review and analysis to determine potential common causes and to identify any necessary corrective actions.

<u>Chronic Conditions and Specific Diagnostic Categories</u>
At-Risk Individuals
The integrated process for addressing individuals' at-risk issues continued to reflect concerns. Based on review records, there appeared to be gaps in assessment, treatment, documentation, and/or follow through to closure. Many of these areas required the cooperation and follow through of the Medical Department as well as other Departments. Two examples are provided in detail:

- On 5/6/13, Individual #130 underwent an EGD and had a gastrostomy tube replaced. On 9/10/13, it was replaced again, and the external bumper was to be monitored to ensure it did not migrate internally and cause a gastric outlet obstruction. On 9/28/13, he then was hospitalized for aspiration pneumonia, and on 12/16/13, he was discharged home from the Infirmary. An ISPA of 12/16/13 did not provide guidance regarding steps to prevent another aspiration pneumonia. The need for timely positioning, the need for monitoring of positioning, the need for the PNMT to review

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		the most appropriate angle for elevation of the head of the bed, and the need to improve his oral hygiene rating that was rated as poor on 1/16/14, were not discussed. Historically, he had GERD and was placed on a proton-pump inhibitor (PPI). He had a history of gastric distention. The date of determination of these diagnoses was not available, but a timely review of the severity of the individual's GERD and gastric emptying would be helpful. The individual might be a candidate for a fundoplication, but there did not appear to be discussion of this option. He had a fracture tibia/fibula on 1/28/14, and the radiologist mentioned potential osteopenia. He was non-ambulatory prior to the fracture. Despite the significant risk of osteoporosis, as of the date of the Monitoring Team visit, the individual had not completed a DEXA scan. One had been ordered for March 2014, but was cancelled, because he had not been kept "nothing by mouth" (NPO). The fracture occurred on the second shift, and there was no discussion whether the staff on that shift needed refresher training using the proper lift with him, or whether staffing was sufficient to meet his needs. He had several risk factors for osteoporosis that included being prescribed life-long antiepileptic medication (i.e., currently prescribed Dilantin), congenital hip deformities, and spastic quadriparesis. It is recommended that the Medical Department review all individuals at high risk for osteoporosis and considers a DEXA scan and indicated treatment based on these results, rather than waiting for a fracture to occur. He was hospitalized on 2/13/14 for a bowel obstruction and found to have a fecal impaction. The ISPA of 2/26/14 did not address steps to prevent another fracture nor how to prevent another fecal impaction. When the individual was discharged from the hospital after treatment of fecal impaction, there did not appear to be any increase in medication or discussion of the need for colon motility studies to determine next step, whether medical or surgical. Without significant additional steps, the risk of recurrent fecal impaction is a high risk. ▪ Individual #333 had not walked for several years, and also sustained a hip fracture. Despite other risk factors, because of the young age (i.e., 28), there had not been a consideration of osteoporosis, and there were no DEXA scan reports to review. He had a seizure disorder and required three anti-epileptic medications and a vagus nerve stimulator (VNS) to improve control of his seizures. Again, it is recommended that a protocol or other systems approach be developed to ensure that individuals at risk for osteoporosis at an early age are identified, and once identified, the potential diagnosis of osteoporosis or osteopenia is confirmed or ruled out with a DEXA scan, and for those with a diagnosis, an aggressive medical management to prevent fractures is implemented. The individual had a gastrostomy tube (G-tube) placement due to meal refusal and refusal to take medication. He had demonstrated ability to eat fast food without problems, but had a long history of meal refusal at CCSSLC. He had a history of oral dysphagia and required a chopped texture diet with thin liquids. On 8/9/11, he had a gastrostomy tube placement for inability to consume sufficient	

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		nutrition. It was noted that in January 2012, he was discharged from psychiatry clinic. On 8/14/12, an esophagogastroduodenoscopy (EGD) was completed with the finding of a small sliding hiatal hernia and gastritis, but no cause for the recurrent vomiting. He was H pylori negative. There was no Barrett's esophagus. There appeared to be several areas needing review and further assessment, based on the limited information submitted for review. That a psychiatrist had not been involved in his care since January 2013 was problematic. Although there might be difficulty with examination, depression needed to be ruled out as a contributing factor for his lack of interest in food, although it was specific to Facility food. The Pharmacy Department needed to review his medication profile to rule out any medications contributing to potential loss of the sense of taste or smell, anorexia, and irritability. Habilitation Therapy needed to conduct an extended open record review to determine the level of independent ambulation in the past, and to review causative factors if there had been a decline, with steps to reverse the process of lack of ambulation. It could not be determined from the submitted information whether the VNS could be contributing to coughing or vomiting. A speech therapist or ENT specialist might provide guidance in those with loss of taste and smell or with altered senses that might contribute to a lack of interest in eating. A dietary consult was needed to determine what his favored off-site foods were and the differences with what was being offered in the residence. This could be due to the aroma of the food, the packaging/wrapping of the food, the mealtime environment (i.e., sitting at a table with music in the background, etc.), the size of the meal, the visual first impression of the meal, the salt content, etc. The IDT should take steps to ensure his swallowing function is maintained and does not degenerate due to lack of regular eating. Referral to a tertiary care center for a second opinion about his anorexia or behaviors might be indicated if the IDT has investigated all areas they believe are contributing to the meal refusal and have not found a correctable cause. Both cases demonstrated the need to improve on the interdisciplinary approach in resolving/preventing recurrence of issues. *GERD* As part of the review of six records, GERD was reviewed. Of the six, five individuals were diagnosed with GERD. Not each individual would have had the listed test or procedure, but the following provides evidence of the spectrum of treatment at the Facility: ▪ Of these five, five had an EGD completed. ▪ Of these five, zero had a fundoplication. ▪ Of these five, five had a feeding tube. ▪ Of these five, five had appropriate medication prescribed. ▪ Of these five, zero had a tracheostomy. ▪ Of these five, two had periodic procedures and tests for monitoring potential worsening of GERD in the past two years.	

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Tracheostomies
Six individuals currently had tracheostomies.

Newly diagnosed chronic conditions
Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. One individual was newly diagnosed with diabetes mellitus type II. No individuals were newly diagnosed with cardiovascular disease. No cases of a newly diagnosed cancer were reported in the past year.

Pica
An updated and complete list of pica or ingestion of inedible objects was submitted for the time period of September 2013 through January 2014. This included 18 events involving 14 individuals. Four pica incidents required an ER visit or hospitalization.

Month	Number of Individuals	Number of Pica Events	ER visit	Hospitalization	Procedure/Surgery
August 2013	4	4	1	0	0
September 2013	1	1	1	1	EGD
October 2013	1	1	0	0	X-ray
November 2013	0	0	0	0	0
December 2013	5	9	1	0	0
January 2014	3	3	1	0	X-ray
Total	**14**	**18**	**4**	**1**	**3**

Chronic Constipation
One hundred eighty-six individuals had a diagnosis of constipation or received treatment for constipation at least weekly. A document entitled: "Individuals diagnosed with bowel obstruction January 2013 to January 2014" listed the number of bowel obstructions per month. The most recent months included the following information:

Month	Number of Bowel Obstructions	Month	Number of Bowel Obstructions
August 2013	0	November 2013	1
September 2013	1	December 2013	0
October 2013	0	January 2014	1

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Total all months	3		

Enteral feeding tubes
The Facility submitted information that six individuals were identified as having jejunostomy tubes or gastro-jejunostomy tubes. A review of the medication profiles was completed to determine whether medications not recommended for administration through these specific tubes or those that had indicated precautions concerning adjustment of dosage were ordered through these enteral tubes (i.e., Quinolones, Sucralfate, Antacids, Bismuth, Beta blockers, Nitrates, Opioids, and Tricyclic anti-depressants). The review indicated that for four of six individuals with gastro-jejunostomy tubes or jejunostomy tubes, these medications were not prescribed through these enteral tubes. One individual with a jejunostomy was prescribed a beta-blocker. This individual also was prescribed morphine, but its administration was sublingual. One individual was prescribed morphine, but submitted documentation indicated the individual had both a gastrostomy tube, a jejunostomy tube, with orders for medication through the gastrostomy and morphine administration orally. It is recommended that the Pharmacy Department review individuals with jejunostomy tubes to ensure appropriate prescribing and dosage adjustments of medications administered by the safest route.

Skin Integrity
A Skin Integrity Committee met 10/23/13 and 12/19/13. Minutes were submitted for these two meetings. In these meeting minutes, the number of active pressure sores was documented. For the prior year, eight of these ulcers originated at the SSLC. Three of these ulcers were noted to begin in the hospital or other setting. There were 10 Stage two ulcers, zero Stage 3 ulcers, zero Stage 4 ulcers, one Stage 1 ulcer, and zero unstageable ulcers. The data from the minutes indicated the following:

Month	Number of New Decubiti	Month	Number of New Decubiti
June 2013	2	September 2013	1
July 2013	0	October 2013	0 (1 according to graph)
August 2013	0	November 2013	2

Data was obtained from the "pressure ulcer report," which was a handout to the minutes. The committee added tracking for "number of days for decubitus to heal" to the database. The graphs also listed one decubitus in October that was not listed in the "pressure ulcer report."

A document entitled "Individuals diagnosed with Decubitus Ulcers" provided updated information for the months of December 2013 and January 2014.

Month	Number of Decubiti	Month	Number of Decubiti
December 2013	2	January 2014	0

Combining information from these two charts, there were a total of eight decubitus ulcers from June 2013

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		through January 2014. *Seizure management* A list was submitted indicating that approximately 138 individuals had a diagnosis of a seizure disorder as of 2/10/14. The Facility submitted information concerning antiepileptic medication usage. As of the Monitoring Team's site visit, 122 individuals were prescribed antiepileptic medication. ▪ Of these, 43 percent (53 individuals) were prescribed one antiepileptic medication, 30 percent (37 individuals) were prescribed two antiepileptic medications, 16 percent (19 individuals) were prescribed three antiepileptic medications, 10 percent (12 individuals) were prescribed four antiepileptic medications, and one percent (one individual) was prescribed five antiepileptic medications. ▪ Nine individuals had VNS implants. ▪ Additionally, 16 individuals with a diagnosis of seizures were on no antiepileptic medications. Twelve individuals were considered to have a refractory seizure disorder. Eight of these had a VNS implant. There was no individual with a refractory seizure disorder who was currently being evaluated for a VNS. Six individuals were diagnosed with status epilepticus. One individual had status epilepticus seven times since the Monitoring Team's last visit. Two individuals each had status epilepticus twice since the Monitoring Team's last visit. A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. A total of 15 percent of individuals with seizures were prescribed Dilantin, zero percent were prescribed Mysoline, two percent were prescribed Phenobarbital, and zero percent was prescribed Felbamate. <u>Do Not Resuscitate Orders</u> A total of 22 individuals at the Facility had DNR orders in place. The date of each DNR was submitted. DNR orders were initiated for 15 individuals in 2013 and seven individuals in 2012. For 12 of 22 (55%), adequate clinical justification was provided for the DNR, although the submitted information was incomplete. Clinical justification included the following: neurological degeneration, respiratory insufficiency, severe osteoporosis, and a terminal condition Not Otherwise Specified (NOS). More information was needed on the terminal indication NOS. Additionally, five individuals had osteoporosis listed as a cause. Although chest percussion would be potentially detrimental to individuals with severe osteoporosis, no information was provided regarding whether consideration was given to use of medications or oxygen, as appropriate. There were 10 individuals without an adequate clinical justification for a DNR order. They were simply listed with "per family request." It is recommended that the Medical Department review the criteria for DNR status and ensure the appropriate documentation is available in the record.	

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		The Facility indicated there was no Ethics Committee meeting in the prior six months. <u>Mock Code Drills and Emergency Response Systems</u> Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Non-facility Physician Case Reviews</u> During the prior six months, the Facility completed one non-facility physician audit review (i.e., Medical Provider Quality Assurance Audit) in December 2013 (Round # 8). The following represents a synopsis of the information: ▪ For the one external peer review dated 12/5/13 to 12/7/13 and 12/13/13 to 12/14/13, PCP compliance for combined essential and non-essential areas compliance ranged from 93 to 98 percent. There was no separate breakdown of compliance for essential areas and non-essential areas. o As a reference, for the prior external peer review audit of June 2013, compliance in essential areas ranged from 84 to 100 percent. Compliance in non-essential areas ranged from 96 to 99 percent. ▪ The external audit review process information did indicate the number of records chosen for review. Twenty-five records were reviewed for the Medical Provider Quality Assurance Audit. ▪ The external audit review process information did indicate how the sample was obtained. ▪ From the external peer review audit, the QA/QI Department provided documentation that there were 40 corrective action plans generated. In December 2013, an external medical management audit for Round #8 was also completed. The three areas of clinical focus were: constipation, urinary tract infections, and seizures. ▪ For the external medical management audit, 25 records were reviewed. Eight records were reviewed for constipation, eight records for urinary tract infections, and nine records for seizures. ▪ From the external medical management audit for Round #8, the QA/QI Department provided documentation that there were 10 corrective action plans generated. ▪ For the constipation medical management audit, compliance per PCP ranged from 93 to 100 percent. ▪ For the seizure medical management audit, compliance per PCP ranged from 75 to 90 percent. It was noted that one of four PCPs was not audited for the seizure medical management audit. For the urinary tract infection medical management audit, compliance per PCP ranged from 50 to 100 percent. This information was provided by the Medical Department and not by an external peer reviewer document or the QA/QI Department. ▪ On 12/14/13, a Medical Provider Exit Interview was conducted by teleconference with the Medical Director. ▪ Areas needing improvement were listed for each individual in which there was a noncompliant finding. There was no summary analysis of this information. ▪ Areas considered strengths were listed/identified as: o It was noted that the medical records were organized.	Noncompliance

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		○ The consultations were considered appropriate. ○ Recommendations from the consultants were followed closely. ▪ Compliance rates were calculated per PCP. ▪ From the QA/QI Department, there was no review of audit results to determine the most common areas of noncompliance that might need additional focus. However, the Medical Department did provide this information when requested during the Monitoring Team's site visit. The most frequent clinical indicators in the external Medical Provider Quality Assurance Audit that indicated non-compliance or need for improvement were the following: ○ (#11) Has the influenza immunization been given? (Three of 25 records noncompliant) ○ (#20) Have the appropriate preventive screenings for bone density been provided? (Three of 25 records noncompliant) ○ (#21) Have the appropriate preventive screenings for lipids been provided? (Three of 25 records noncompliant) ○ (#22) Have the appropriate preventive screenings for Thyroid Stimulating Hormone been provided? (Six of 25 records noncompliant) ○ (#27) Is the current 180-day Physician Order present in the record, and does it document the indication for each medication…? (Three of 25 records noncompliant) ○ (#28) Is there evidence that the Provider responded to the Pharmacist Quarterly Drug Regimen review recommendations on the Quarterly Drug Regimen Review Form within 15 business days? (Three of 25 records noncompliant) ○ (#39) Do notes regarding acute medical problems contain pertinent positive and negative findings? (Four of 25 records noncompliant) ○ From the medical management audit, there was one identified clinical indicator of concern. Fort the seizure medical management audit: • (#2) Did the PCP complete appropriate labs at least every six months? (Four of 25 records noncompliant) A follow-up system was implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. ▪ The QA Nurse/QI Department compiled compliance data with corrective action plans. These indicated: ○ The QA Department tracked corrective action plan resolution every 30 days until resolution. Review dates listed included 1/9/14, 2/5/14, 2/6/14, and 2/7/14. ▪ At the time of the Monitoring Team's visit, the QA Department determined that 15 of 40 (38%) corrective action plans for the external general medical peer review audit had been completed. The last date of QA monitoring documented was 2/7/14. ▪ At the time of the Monitoring Team's visit, the QA Department determined that seven of 10 (70%) corrective action plans for the external medical management peer review audit had been completed. The last date of QA monitoring documented was 2/7/14. ▪ The Medical Department submitted information that there were 17 corrective action plans for the external medical management peer review audit. At 60 days, 14 of 17 (82%) had been completed.	

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		The reason for the discrepancy in information between the data from the QA Department and from the Medical Department was not determined, but needed further review by both departments. <u>Mortality Reviews</u> At the time of the review, the Facility had no outstanding clinical death reviews for deaths that occurred more than 30 days from the Monitoring Team's visit. One clinical death review was undated, but appeared to occur in a timely manner. Since the start of the Monitoring Team's last visit, three deaths had occurred: ▪ The average age was 46 (varied from 35 to 57). ▪ All three died under the age of 65. ▪ Of the deaths, one was female, and two were males. ▪ The causes of death were available for two of three: sepsis and pneumonia were listed for two individuals. Record review indicated there might have been other contributing causes to the change in health status. The etiology of the third death was pending autopsy findings. The death certificate was received for one of three. ▪ An autopsy was performed in two of the three. ▪ DNR status (out of hospital) was ordered while residing at CCSSLC for one of the three, and was also ordered for this individual in the hospital. ▪ Two died in a hospital setting. ▪ None died at the Facility. ▪ One died at another site. ▪ Two had prior hospitalizations within four months prior to death. ▪ Two had feeding tubes. ▪ Two included documentation indicating they were aggressively treated or aggressively treated until a decision of DNR was made. ▪ None were enrolled in hospice, although one received palliative care as part of terminal care. ▪ One was considered ambulatory (either independently or with assistance). ▪ None required oxygen supplementation routinely. Since the Monitoring Team's last visit, three clinical death review investigations, and three administrative death reviews were completed. Clinical death review recommendations and nursing QI death review recommendations were discussed at the administrative death reviews. The administrative death reviews recorded the final list of recommendations for the death review process of the individual. Of these death reviews, three of three administrative death reviews had follow-up recommendations. • Administrative death reviews included from one to four recommendations per review, for a total of 10 recommendations determined by the administrative death review committee. There were six additional recommendations listed in the Unusual Incident Report (UIR) that were also tracked by administration. The Facility Administration tracked sixteen recommendations. o Systemic issues related to potential improvements in medical care were three of the 16 recommendations from the administrative death reviews. o Systemic issues related to potential improvements in nursing care were three of the 16	

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		recommendations from the administrative death reviews. ○ Systemic issues related to potential improvements in transition of care to the ER, hospitalization, rehabilitation or nursing home, or hospice were zero of the 16 recommendations from the administrative death reviews. ○ Systemic issues related to potential improvements in pharmacy services were zero of the 16 recommendations from the administrative death reviews. ○ Systemic issued related to potential improvements in dental services were zero of the 16 recommendations from the administrative death reviews. ○ Systemic issues related to potential improvements in habilitation therapies were zero of the 16 recommendations from the administrative death reviews. ○ Systemic issues related to potential improvements in IDT processes were eight of the 16 recommendations. ○ Systemic issues related to potential improvements in investigations were one of the 16 recommendations from the administrative death reviews. ○ Systemic issues related to documentation were one of the 16 recommendations from the administrative death reviews. ○ Systemic issues related to potential improvements in other departments (i.e., maintenance, housekeeping, furlough, etc.) were zero of the 16 recommendations from the administrative death reviews. • The Facility indicated closure of 14 recommendations with pending closure of two recommendations. The evidence submitted provided closure for eight of 16 recommendations. For four recommendations, training was indicated, but no denominator for the number of staff requiring the training was indicated. The process for tracking adequate training without a denominator was not clear. Nursing training rosters did include a denominator for one of two nursing trainings. There appeared to be delays in completing the recommendations for several months. There was no proof of closure for two medical recommendations. In some instances, follow-up did not occur until the Monitoring Team member requested information concerning closure. For example, there was a weekend/holiday log for the PCPs to sign-in when rounding in the Infirmary, but this had only been created the week of the Monitoring Team visit, and there was no demonstration it had been implemented. Additionally, there was an email that was forwarded to the PCPs concerning EKGs to be done in individuals with a diagnosis of diabetes insipidus. There was no evidence this was being done, such as a chart indicating names of individuals with this diagnosis and dates of EKG completion. These recommendations occurred at administrative death review committee meetings from December 2013 and January 2014. There was a delay in implementation of these recommendations, and these attempts at ensuring closure indicated there was no formal system to track closure of recommendations in a timely manner. It was not clear if these recommendations would have been acted upon without the inquiry from the Monitoring Team member. • A rigorous system to track closure of recommendations is a needed aspect of this process, along with timelines assigned, and tracking to ensure timelines are met, but such a system appeared to be missing. This would be a role for the QA Department or other administrative department. Additionally, there was one recommendation that appeared to apply campus-wide, but only was	

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		trained on one Unit. Credit for closure was provided (although there was no denominator indicating the number of staff in that unit for whom the recommendation was intended). However, it appeared the recommendation might have been intended or could apply to all the residences. A review of the clinical and administrative death reviews revealed the need for improvement. One of the individuals died in the hospital, but during the interval of time prior to transfer, at least one medication error had occurred. Increased monitoring followed and the individual was subsequently hospitalized. This medication error was categorized as a Category C, when it was a Category F that should have led to a root cause analysis. When departmental leadership was asked the reason for the medication variance, there was no clear answer given. The Monitoring Team member then met with the Pharmacy Director, who provided an in-depth review of the circumstances involving the medications. Some of the information had not been previously available, but should have been part of a root cause analysis. The Pharmacy Department provided clear evidence as to the number of doses administered and not administered, indicating medication was available but not administered. This led to other concerns that remained unresolved, and were not investigated/reviewed. The role of the QA Department in directing the review appeared to be limited or absent. The outcome should have been a systems approach to implementing strategies to prevent a recurrence to ensure safety of the individuals and provide support to the staff, but the lack of a root cause analysis with interdepartmental input resulted in such actions not being identified or taken. It is recommended that the Facility review the quality of the clinical and administrative death reviews to ensure areas needing improvement are identified and systemic plans are implemented to prevent a recurrence. Although there was Nursing Department training of all staff concerning a policy already in place, it remained unresolved how the medication variance occurred. Until that reason is determined, the Facility cannot be assured that the preventive steps taken have resolved the problem. In summary, the CCSSLC mortality review system required review and improvement, and the Facility needed to develop and implement a system to track the recommendations to conclusion. The non-facility physician reviews were occurring, and the Facility had a system to track the action plans that resulted from these reviews through to completion. However, it appeared there were discrepancies between the Medical Department and QA Department's tracking. In addition, the Facility needed to regularly review the deficiencies to identify any need for more systemic action and/or training, and act on these findings. Another concern was the fact that these reviews included limited topics, and did not comprehensively assess the quality of medical care at the Facility. CCSSLC remained in noncompliance with this provision.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two	<u>Medical Department Internal QA System</u> Information was provided for three internal medical peer reviews. *Internal Medical Provider Quality Assurance Audit of September 2013* The data from Round #7 internal medical peer review was provided. This peer review occurred in September 2013. The audit questions were identical to those used in the external medical peer review audit. Compliance for PCPs in essential areas ranged from 97 to 100 percent. Compliance for PCPs in non-essential areas ranged from 68 to 84 percent.	Noncompliance

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	years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	For the internal medical peer review audit, there were 35 corrective action plans identified for six PCPs. There was information submitted concerning tracking these corrective action plans to closure. QA had tracked action plans on 12/1/13, 12/2/13, and 12/3/13. The most current information submitted during the Monitoring Team's visit indicated eight corrective action plans had been completed. This was determined from raw data, because the QA Department did not submit summary information. There did not appear to be QA monthly monitoring for the completion of the corrective actions for the September 2013 internal general medical peer review. *Internal Medical Management Peer Review Audit of September 2013* An internal medical management audit was completed in September 2013, utilizing the same audit questions from the external medical management peer review for the following clinical concerns: osteoporosis, aspiration pneumonia, and diabetes mellitus. It was noted that the clinical indicators in the audit addressed whether lab values were ordered for Vitamin D levels, but it was not a sufficiently sensitive tool to detect under-treatment of Vitamin D (i.e., whether treatment achieved the goal of normal Vitamin D levels). Review of the evaluation results for secondary causes of osteoporosis is discussed in further detail with regard to Section L.1. There were a significant number of individuals with low Vitamin D levels for those with osteoporosis/osteopenia, but internal monitoring had not identified this issue. For the internal medical management peer review audit, there were 27 corrective action plans identified. This was determined from raw data, because the QA Department did not submit summary information. There was information submitted concerning tracking these corrective action plans to closure. The submitted monitoring data from QA indicated that plans had been reviewed by QA with updates listed as 12/2/13 and 12/3/13. Fifteen corrective action plans had been completed, according to the raw data. *Internal Medical Provider Quality Assurance Audit of December 2013* The data from Round #8 internal medical peer review was provided. This peer review occurred in December 2013. The audit questions were identical to those used in the external medical peer review audit. Compliance for PCPs in essential areas was not submitted. Compliance for PCPs in non-essential areas ranged from 91 to 99 percent. Compliance for the combined essential and non-essential components ranged from 95 to 99 percent per PCP, or 94 to 98 percent per PCP, depending on the document reviewed. The reason for the variation in reported data was not determined, but the differences were small. Areas that appeared to need improvement included answers to the following audit probe questions: ▪ (#8) If the individual uses tobacco products, was there documentation for recommendation for cessation of tobacco use? (Five of 25 records were noncompliant.) • (#24) Have the appropriate preventive screenings for hearing been provided? (Three of 25 records were noncompliant.) • (#26) Was the Preventive Care flow sheet updated at the time of the last annual assessment? (Three of 25 records were noncompliant.)	

#	Provision	Assessment of Status	Compliance
		For the internal medical peer review audit of December 2013, there were 29 corrective action plans identified. There was information submitted concerning tracking these corrective action plans to closure. QA had tracked 29 of 29 action plans during the follow-up on 2/10/14. The most current information submitted during the Monitoring Team's visit indicated 15 of 29 corrective action plans had been completed. *Internal medical management audit of December 2013* An internal medical management audit was completed in December 2013, utilizing the same audit questions from the external medical management peer review for the following clinical concerns: constipation, seizures, and urinary tract infection. Compliance among PCPs was reported in a document the Medical Department submitted. This information was not provided by the QA Department. For the constipation medical management peer review audit, compliance per PCP ranged from 50 to 100 percent. For the seizure medical management peer review audit, compliance was 100 percent for three PCPs. There was no measurement indicated for one PCP. For the urinary tract infection medical management peer review audit, compliance per PCP ranged from 50 to 100 percent. Areas that appeared to need improvement included answers to the following audit probe questions: ▪ Constipation (#3) Is there evidence that the PCP documented follow-up effectiveness of the treatment plan including side effects? (Two of eight records were noncompliant.) ▪ Constipation (#4) Is there evidence that the PCP ordered non-pharmacological treatments? (Two of eight records were noncompliant.) ▪ Urinary tract infection (#1) Is urinary tract infection listed on the active problem list? (Two of eight records were noncompliant.) ▪ The clinical indicators for the seizure audit did not indicate need for improvement. For the internal medical management peer review audit in December 2013, there were five corrective action plans identified. There was information submitted concerning tracking these corrective action plans to closure. These five corrective action plans were for three PCPs. The submitted monitoring data from QA indicated that five of five plans had been reviewed by QA, and the information submitted during the Monitoring Team's visit indicated one of five corrective action plans had been completed. Dates of follow-up could not be determined. *Internal Medical Provider Quality Assurance Audit of March 2014* Information was provided by the Medical Department for the internal medical provider quality assurance audit of March 2014. Compliance per PCP for all clinical indicators was 93 to 98 percent. Twelve charts were reviewed for this audit. The most frequent clinical indicators needing improvement were identified: ▪ (#2) Is there evidence that the Active Problem List was updated with each new problem? (Two of 12 records were noncompliant.)	

#	Provision	Assessment of Status	Compliance
		▪ (#8) If the individual uses tobacco products, was there documentation for recommendation for cessation of tobacco use? (Two of 12 records were noncompliant.) ▪ (#15) Has the Zostavax (if age over 60) been given? (Two of 12 records were noncompliant.) ▪ (#20) Have the appropriate preventive screenings for bone density been provided? (Two of 12 records were noncompliant.) ▪ (#26) Was the Preventive Care flow sheet updated at the time of the last annual assessment? (Three of 12 records were noncompliant.) ▪ (#42) Did the provider indicate resolution and closure of acute problems in the integrated progress note? (Two of 12 records were noncompliant.) *Internal Medical Management Audit of March 2014* For the constipation medical management peer review audit, compliance per PCP ranged from 50 to 88 percent. For the seizure medical management peer review audit, compliance per PCP ranged from 89 to 100 percent. For the urinary tract infection medical management peer review audit, compliance per PCP was 100 percent for three of four PCPs. No record sample was identified for this diagnosis for one PCP. The most frequent clinical indicators needing improvement were identified: ▪ Constipation (#1) Is constipation listed on the Active Problem List? (Two of 16 records were noncompliant.) ▪ Constipation (#3) Is there evidence that the PCP documented follow-up effectiveness of the treatment plan including side effects? (Four of 16 records were noncompliant.) ▪ Constipation (#4) Is there evidence that the PCP ordered non-pharmacological treatments? (Five of 16 records were noncompliant.) There were no clinical indicators for the seizures or urinary tract infection audits that indicated need for improvement. The Medical Department indicated that there were 13 corrective action plans for the internal medical management audit of March 2014. Follow-up by QA was not due until 4/12/14. <u>Inter-rater reliability</u> The QA Department did not provide the inter-rater reliability data for the past six months. The Medical Department indicated that the QA Department had not provided the methodology used in calculating inter-rater reliability. The QA Department, with guidance from the State Office, would be expected to provide the appropriate calculations. Percentage of agreement was provided for the medical provider quality assurance audit. Agreement in responses was 81 percent. For the medical management audit, agreement was 85 percent for the constipation audit, 67 percent for the seizure audit, and 66 percent for the urinary tract infection audit. The Medical Director indicated the need to use alternative calculations, as the Medical Director believed the percentage of agreement methodology did not provide the needed calculation for inter-rater reliability. The State Office should review this concern, keeping in mind that the standards are different for research than they are for auditing records. The goal is simply to assure that monitoring results can be	

#	Provision	Assessment of Status	Compliance
		replicated from reviewer to reviewer. <u>Medical Department Internal Reviews/ Initiatives and Improvement Projects</u> The Medical Department implemented the following additional processes for internal review initiatives: ▪ Quality indicators were identified for seven clinical areas, independent of the audit tools utilized in the external and internal medical peer review and medical management peer review process. Topics included: seizures, ER visits and hospitalizations, Down syndrome, osteoporosis, constipation, hypertension, and diabetes mellitus. ▪ The audit process of these additional internal reviews started between December 2012 and April 2013. Data was collected either monthly or quarterly, depending on the clinical topic. o For seizures, data was collected for April 2013, July 2013, October 2013, and January 2014. There were clinical indicators measured. For two indicators, compliance was 100 percent: "anti-epileptic drug levels are drawn every 6 months and when clinically indicated," and "Ativan/Diastat was used appropriately for PRN seizure control." For the clinical indicator: "Consultation with a neurologist occurs at least every 1-2years," compliance dropped from 100 percent in April 2013 to 44 percent in October 2013, and increased to 89 percent in January 2014. For the clinical indicator: "Seizure frequency is documented on the seizure graph," compliance dropped from 100 percent in April 2013 to 0 percent in January 2014. For each month monitored, seven to nine records were reviewed. ▪ For ER and hospital admissions, there were five clinical indicators. Months audited included April 2013, May 2013, June 2013, July 2013, September 2013, and December 2013. Compliance ranged from 83 to 100 percent for each clinical indicator. Four clinical indicators reached 100 percent compliance. For December 2013, eight records were reviewed. ▪ For Down syndrome, reviews were completed in June 2013 and January 2014. There were five clinical indicators, and for all five, compliance was 100 percent. ▪ For osteoporosis, reviews were completed November 2012, June 2013, September 2013, and December 2013. There were six clinical indicators measured. Three of six had 100 percent compliance in December 2013. These included the following clinical indicators: o Medical management includes a bisphosphonate (or alternative), calcium, and Vitamin D? o Most recent Vitamin D-25-OH was optimal? o If supplementation is not needed, is dietary intake adequate? o The following had low compliance scores: • DEXA scan current? (33%) • Is patient immobile? (33%). The interpretation of this clinical indicator needed further clarification. • Has the patient had a fracture within the past year? (22%). The interpretation of this clinical indicator needed further clarification. As noted earlier, these clinical indicators did not appear to measure whether the treatment goal was accomplished, but indicated whether a series of steps (i.e., tests, etc.) were ordered based on a diagnosis.	

#	Provision	Assessment of Status	Compliance
		▪ For constipation, reviews were completed April 2013, July 2013, October 2013, and January 2014. There were five clinical indicators. For the January 2014 review, there were two clinical indicators with 100 percent compliance: "Fiber supplement ordered if needed," and "surgical intervention was not required within the last year." Additionally, for one clinical indicator, "A GI consult has been ordered if needed," the sample reviewed did not include an applicable case. o The following two clinical indicators needed improvement: • Nutritional consult performed recommending amount of dietary fiber intake? (43%) • Medical management ordered? (43%) ▪ For hypertension, reviews were completed May 2013, August 2013, and November 2013. There were six clinical indicators. Four of six attained 100 percent compliance: o A Heart Healthy diet is ordered? o If there is diabetes mellitus comorbidity, is blood pressure less than 135/90? o An annual lipid panel is present? o An ophthalmology exam is performed every one to two years? o There were two clinical indicators with less than 90 percent compliance: • Blood pressure less than 140/90? (89%) • Is there obesity co-morbidity? (25%). The interpretation of this clinical indicator needed further clarification. ▪ For diabetes mellitus, reviews were completed May 2013, August 2013, and November 2013. For the November 2013 audit, there were seven clinical indicators. Four of seven attained 100 percent compliance: o Hemoglobin A1C is performed yearly? o Blood pressure is less than 135/90? o Ophthalmology exam is performed yearly? o Dietary consult has been performed? o There were three clinical indicators with less than 90 percent compliance: • Urine microalbumin is performed yearly? (11%) • Podiatry exam is performed yearly? (44%) • Appropriate diet has been ordered? (89%) The Medical Department provided evidence of a developing quality improvement program. The growing number of quality indicator provided evidence of reviews of quality care, which was reassuring and necessary. The Medical Department should continue this process, with focus on areas needing improvement. Areas in which improvements continued to be needed included: ▪ As is discussed with regard to Sections L.1 and I.2, the Monitoring Team was continuing to identify issues that the Facility's internal processes were not identifying. For example, problems were identified with regard to the treatment of individuals with osteoporosis. It is essential that the Facility's internal medical quality assurance systems identify such issues, and develop and implement corrective actions to address them. The Facility should review the current audit tools	

#	Provision	Assessment of Status	Compliance
		and processes, and refine them to ensure they are sensitive enough to identify such issues. ▪ As is discussed with regard to Section H, the Medical Department also needed to demonstrate creation of audit tools with clinical indicators focusing on the actual clinical values of tests and radiographic reports, etc., to determine whether the current treatment was adequate or needed to be changed (e.g., change dosage, add medication, remove medication, other therapies added, etc.). When change was indicated, the audit should measure whether there was evidence that change occurred through PCP orders, and whether this was done in a timely manner, along with orders for further monitoring to determine improvement or lack of improvement, need for further consultation, or need for further lab testing, scans, etc. ▪ Reasons for delays of up to 90 days for the completion of corrective actions resulting from internal quality reviews required review, and determination of whether actions were needed to improve the timeliness of these activities. ▪ Based on the results of the internal and external reviews, it did not appear that inter-rater reliability had been established. The Facility remained in noncompliance with this provision.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The	Since the Monitoring Team's last visit, the following policies/procedures/protocols were approved and/or implemented: ▪ "Medical Care: Processes and Guidelines– How to Create a Random Sample in Excel," approved 2/6/14; ▪ "Medical Care: Processes and Guidelines – Guidelines for Infirmary Observation for Fever or Unstable Vital Signs," approved 2/6/14; ▪ "Medical Care: Processes and Guidelines – Guidelines for Integrated Clinical Services Meeting Attendance," approved 2/6/14; ▪ "Medical Care: Processes and Guidelines - Guideline on How to Use the Quarterly Medical Review," approved 2/6/14; ▪ "Medical Care: Processes and Guidelines - Guidelines on How to Conduct a Chart Review for Cases Being Admitted to the Hospital or Infirmary," approved 2/6/14; ▪ "Medical Care: Processes and Guidelines – guidelines for using the Quality Indicators for UTI Monitoring Tool," approved 2/6/14; and ▪ "Quarterly Medical Review" template form, approved 2/6/14. Recent policies in draft format included the following: ▪ "CCSSLC- Health Services: Out-of-Hospital do not resuscitate orders and life threatening medical treatment," draft 3/27/14; and ▪ "Administration: Ethics Committee," draft/revision 11/6/13. Additional documents were submitted as part of the Medical Department policy and procedure manual. Included were:	Noncompliance

#	Provision	Assessment of Status	Compliance
	Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	▪ "New Screening Guidelines for Cervical Cancer – American Cancer Society" (article date 3/14/12). This was not in the format of a policy, and was undated, without an indication of whether this was in draft form, approved, or implemented; ▪ "Guidelines on when to develop an ISPA after a consult," written 2/11/14; ▪ "Seizure management Instructions for the PCP," dated 10/30/13; and ▪ "Diabetic Keotacidosis and hyperosmolar hyperglycemic state for the PCP," dated 10/10/13. The above updates and documents that were to be reviewed, approved, and implemented represented ongoing progress in developing a policy and procedure manual that provides clarity to all the Medical Department services and systems. There were some more recent documents that provided updates and covered the same topics as older policies, but these older policies were not removed from the documents provided. The following areas needed to be addressed, and/or placed in one section of the policy manual: ▪ Staffing and administration - development of caseloads, categories of topics for CME, CPR certification, etc.; ▪ Formalized policy/procedure on the process of the Integrated Clinical Services meeting, along with systems in place to ensure timely response to closure concerns, etc.; ▪ Updating preventive care guidelines; ▪ Implementation of the quality indicators submitted for review; ▪ Development of a system to track all missed appointments; ▪ Resolution of analysis for inter-rater reliability; ▪ Components of a mortality review and when to determine the need for a root cause analysis; and ▪ Policy to address frequency of review of each of the documents.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC's Self-Assessment; o CCSSLC At-Risk Individuals list; o CCSSLC's Nursing Department Presentation Book; o CCSSLC's Section I Presentation Book; o CCSSLC's Monitoring Tools for Nursing and raw data; o CCSSLC's minimum staffing numbers for nursing; o CCSSLC's Infection Control Monitoring Tools data; o CCSSLC's Corrective Action Plans for Section M; o CCSSLC's lists of individuals who were seen in the Infirmary, emergency room, and hospital; o Medication Variances Monthly Summary data reports; o Daily Check of Emergency Cart data; o Medication Excess/Shortages data; o Medication Administration Observation tracking and data; o Emergency Equipment Checklists data; o Medical records for the following individuals: Individual #122, Individual #189, Individual #86, Individual #348, Individual #238, Individual #147, Individual #275, Individual #366, Individual #369, Individual #268, Individual #243, Individual #292, Individual #321, Individual #290, Individual #247, Individual #130, Individual #239, Individual #218, Individual #78, Individual #335, Individual #144, Individual #79, Individual #205, Individual #356, Individual #3, Individual #340, Individual #304, Individual #141, Individual #239, Individual #340, Individual #130, Individual #252, Individual #183, Individual #205, and Individual #44; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD) converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o Real Time Audit tool data for Infection Control; o CCSSLC Outbreak timelines; o Infection Control Committee meeting minutes, dated 10/23/13, 1/31/14, and 2/12/14; o CCSSLC's monthly Infection Control summary reports; o CCSSLC Immunization data; o Drug Utilization Discrepancy data; o Drug Utilization Reports - Antibiotics; o Weekly Infection Control Reports; o Pneumonia Tracking Reports; o Infection Control Environment Checklists data; o Medication Variance information from Pharmacy;

	○ Medication Committee meeting minutes, dated 8/22/13, 10/3/13, 10/30/13, 11/20/13, and 12/18/13, and 1/22/14; ○ Medication Administration Observation data; ○ Monthly Emergency Medical Drills reports; and ○ CCSSLC Emergency Medical Drills tracking and data. ▪ **Interviews with**: ○ Michael Robinson, MSN, RN-BC, Chief Nurse Executive (CNE); ○ Colleen M. Gonzales, BSHS, Nurse Operations Officer (NOO); ○ Peggy Sue Miclan, RN, Program Compliance Nurse (PCN); ○ Jennifer Graves, RN, Quality Assurance; ○ Della Cross, RN, Nurse Educator; ○ Kristen Middleton, RN, Nurse Educator; ○ Pamela Nichols, RN, Infection Control (IC)/Employee Health Nurse; ○ Michelle Warren-Pile, RN, BSN, Assistant Infection Control Nurse; ○ Patty Glass, RN, Nurse Case Manager Supervisor; ○ Gary Frech, MSPharm, RPh, Director of Pharmacy; ○ Brandon Riggins, Assistant Director of Programs; ○ Rachael Martinez, QIDP Coordinator; ○ Melinda Eldrige, Competency Training Department (CTD), Director, and; ○ Michael Gilby, Competency Training Department, Instructor. ▪ **Observations of**: ○ Medication Administration in the Infirmary; and ○ Use of emergency equipment at the Infirmary and Sand Dollar.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section M, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools and was in the process of developing promising instructions for each tool. (Specific details are provided with regard to Section M.1.) At the time of the review, the Facility had implemented the nursing monitoring tools. However, based on a review of the Facility's Self-Assessment: ○ It was unclear what specific criteria were used to determine compliance addressing the quality of the nursing documentation. ○ In most of the subsections for Section M, many of the items presented did reflect the requirements of the specific provision. However, in some areas, the data presented did not reflect the requirements. As the Facility reviews its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ In addition, due to turnover in the Quality Assurance Nurse position, some inter-rater reliability percentages were not available or very low for some of the monitoring tools.

	Continued efforts are needed to improve this area in order to ensure consistency in monitoring and the validity of the results. ▪ Although there continued to be significant improvement in the presentation of the data that was contained in the Facility's Self-Assessment for Section M, some problematic issues were noted. Specifically, the Facility's Self-Assessment: o Did not consistently present findings based on specific, measurable indicators. For example, as noted above, at times, it was unclear what criteria or standard had been used to determine compliance related to adequate nursing services and documentation, such as a nursing protocol. Some of the data provided did not address the quality of nursing services and related documentation, but merely the completion or presence of documentation. o On a positive note, there was significant improvement noted regarding the identification of the sample sizes used for some of the monitoring, including the description of the overall population from which the sample was selected (N) and a percent sample size. o As noted in previous reports, the Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. ▪ The Facility rated itself as being in compliance with none of the subsections of Section M. This was in alignment with the findings of the Monitoring Team. ▪ The Facility's data identified some of the areas that were in need of improvement and provided promising interpretations of the information, including identifying some potential causes for the issues, and possible barriers to improvement, and connecting problematic findings to portions of the Facility's Action Plans.
	Summary of Monitor's Assessment: Since the last review, there were no changes in the key leadership positions in the Nursing Department. However, CCSSLC did have some changes regarding the nursing positions, which included: ▪ The Porpoise building was closed since the last review; ▪ The Facility was in the process of converting three Registered Nurse positions into 4.5 Licensed Vocational Nurse (LVN) positions; ▪ Four LVN II positions were converted into LVN III positions; ▪ Minimum staffing for Coral Sea medication nurses was increased from four to six on day and evening shifts; and ▪ Minimum staffing for Ribbonfish medication nurses was also increased from four to five on the day and evening shifts. At the time of the review, the Nursing Department had a total of 112.1 allotted positions, including 59.7 for RNs and 52.4 for Licensed Vocational Nurses. At the time of the review, the total nursing position fill rate was 99% for the RN positions, and 79% for the LVN positions. From a review of the Facility's nursing staffing data and discussions with the Chief Nurse Executive (CNE), since the last review, the Nursing Department had continued to experience staffing challenges and in January 2014, began using agency nurses to decrease overtime and assist in retention of current nursing staff.

	Some of the Facility's positive steps forward included: ▪ The Facility continued to monitor the process addressing data reliability, to accurately identify the Facility's trends related to infectious and communicable issues. From data generated by comparing the Infection Control Reports, Infection Control Logs from the residences, and the Pharmacy reports for the utilization of antibiotics, the following compliance percentages reflected the data reliability checks for Infection Control: 97%, 100%, 100%, 99%, 100%, and 98% from August 2013 through January 2014, respectively. ▪ Based on the ISP schedule, the Facility continued to review individuals' complete immunization histories and update any needed laboratory work or immunizations, as appropriate. At the time of the review, 71% of the individuals had had their immunization information brought up-to-date. ▪ In January 2014, the Facility conducted its first clinical review of the Mock Code Drills at the Nursing QA meeting. In addition, in February 2014, staff from the Competency Training Department and the Nurse Educators also met to review the Emergency Mock Code Drill data. ▪ Regarding nursing assessments, it was clear to the Monitoring Team that the Facility was in the beginning stages of focusing its efforts on improving the documentation contained in the Comprehensive Nursing Assessments. Although not consistently found in most of the assessments the Monitoring Team reviewed, improvement was noted regarding the Summary Section of the Comprehensive Nursing Assessments. ▪ In addressing medication variances, in November 2013, nursing had assumed responsibility for the medication excess/shortage forms. The Nurse Managers were responsible for investigating all unknown excesses and shortages in their buildings. The Facility's Unreconciled Medications data from 8/1/13 through 1/31/14 reflected that progress had been made in identifying the causes for unknown excesses and shortages of medications. Clearly, the Facility had made steady positive steps forward in the areas noted above. However, there continued to be an overall lack of progress found regarding the care plans, the implementation of nursing protocols for existing conditions and documentation in response to changes in status, which was very concerning at this juncture in the review process.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2 and M.3 of the Settlement Agreement. Information addressing nursing documentation regarding restraints is included above with regard to Section C.	Noncompliance

#	Provision	Assessment of Status	Compliance
	physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	In assessing its progress, CCSSLC indicated in the Facility's Self-Assessment that the following steps were initiated since the last review regarding this requirement of the Settlement Agreement: ▪ The Facility's Self-Assessment indicated that the following data reflected the Registered Nurse and Licensed Vocational Nurse staffing fill rate for 8/1/13 through 1/31/14:	

	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014
RN positions	59.7	59.7	59.7	57.9	57.9	57.7
Filled	57.2	59.7	59.7	57.4	57.9	57.2
Fill rate %	95%	100%	100%	99.1%	100%	99%
LVN positions	52.40	52.40	52.40	54.40	54.40	54.40
Filled	41.9	42.9	42.9	46.9	48.4	43.4
Fill rate %	78%	82%	82%	86%	89%	79%

The Facility indicated that the findings from a time study resulted in the reallocation of medication nursing positions as described below.

▪ The Facility's review of the Hospital/Infirmary Prevention Health Monitoring tools (HMT) from 8/1/13 through 1/31/14 indicated the following findings:

Hospital Prevention Tool	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014
N= total number of individuals admitted to Infirmary or Hospital	16	16	6	16	12	14
n= actual number of audited	16	16	6	16	12	14
% S (Sample)	100%	100%	100%	100%	100%	100%
Inter Rater Agreement	71%	53%	82%	53%	59%	76%
Compliance rate: # 4a Performed appropriate assessments as dictated by the affected and related system(s)	47%	24%	13%	42%	31%	38%

#	Provision	Assessment of Status							Compliance
		Compliance rate: # 4c Licensed nursing staff shall notify physician of health care problems	87%	96%	38%	80%	100%	78%	
		Compliance rate: # 5 An Acute Care Plan was developed, including instructions for Implementation	36%	10%	50%	45%	73%	41%	
		Compliance rate: # 6 Conducting frequent evaluations of the individuals clinical condition to ensure the appropriateness of treatments and facilitate the individuals' recovery	61%	15%	50%	38%	42%	39%	
		Compliance rate: # 7 Licensed nursing staff informed the Medical Provider in a timely manner of problems that require medical evaluation and intervention	87%	79%	38%	65%	70%	59%	
		The Facility indicated that the low percentage regarding inter-rater reliability was attributed to a new Quality Assurance Nurse taking over the auditing duties, and since that time, the Program Compliance Nurse and QA Nurse were working closely together							

#	Provision	Assessment of Status	Compliance

to improve their understanding of the tools. The Self-Assessment indicated: "the scores on this graph show a lack of consistency in documentation. We will be focused on reviewing these percentages monthly, in an effort to increase the quality and consistency of our documentation and working with the nurses involved. Action Plans are in place under M1 step 1, M2 step 4 and M3 step 2."

- The Facility's review of the findings regarding the Real Time Infection Control Health Monitoring tool from 8/1/13 through 1/31/14 are noted below:

	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014
N= total number of Infections	32	38	36	50	25	33
n= number of Infections with Nursing Care Plan (NCP) in place	26	37	35	47	24	33
% Infections with NCP	81%	97%	97%	94%	96%	100%
Actual number of audited	6	3	4	5	6	5
% S (Sample)	19%	8%	11%	10%	24%	15%
Inter rater Agreement	n/a	n/a	n/a	78%	78%	33%
Compliance rate: # 1 Has there been a care plan implemented for actual or potential infectious illness?	100%	100%	100%	100%	100%	100%
# 3a Is the NCP appropriately personalized for the specific resident?	17%	0%	0%	80%	83%	60%
#4 b Proper Standard and/or Isolation precautions are in place?	34%	33%	75%	20%	67%	80%

#	Provision	Assessment of Status	Compliance

#4c Education/training for staff and residents was implemented?	0%	0%	50%	60%	83%	100%	

The Self-Assessment indicated that the low inter-rater agreement percentage for January 2014 was due to the QA Nurse not being able to find the NCPs in the active record "at the time the audits were completed." The Facility indicated: "the data shows real progress on having a NCP implemented, however we are continuing to mentor the nurses on personalization, documenting that isolation is in place and education of the staff."

- In addition, the Facility's review of 100% of the Infection Control audits of the IPN documentation from 8/1/13 through 1/31/14 indicated the following compliance scores:

	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014
N= total number of Infections	32	38	36	50	25	33
n= actual number of audited	6	7	6	7	5	5
% S (Sample)	19%	19%	17%	14%	20%	15%
Inter rater Agreement	-	56%	-	58%	58%	84%
Compliance rate: # 1a Documentation completed for 72 hours	50%	71%	50%	43%	60%	60%

The Facility indicated that the data reflected that there was a need for further training and follow-up with nursing regarding nursing documentation.

Self Rating

The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in substantial compliance. We continue to complete HMT and provide mentoring to nurses. Action plans are in place under M.4 step 2 and 3 and corrective action plans are completed as systemic issues are identified."

#	Provision	Assessment of Status	Compliance
		Staffing At the time of the review, CCSSLC had a census of 231 individuals. Since the last review, there were no changes in the key leadership positions in the Nursing Department. However, CCSSLC did have some changes regarding the nursing positions, which included: ▪ The Porpoise building was closed since the last review; ▪ The Facility was in the process of converting three Registered Nurse positions into 4.5 Licensed Vocational Nurse positions; ▪ Four LVN II positions were converted into LVN III positions; ▪ Minimum staffing for Coral Sea medication nurses was increased from four to six on day and evening shifts; and ▪ Minimum staffing for Ribbonfish medication nurses also was increased from four to five on the day and evening shifts. At the time of the review, the Nursing Department had a total of 112.1 allotted positions, including 59.7 for RNs and 52.4 for Licensed Vocational Nurses. At the time of the review, the total nursing position fill rate was 99% for the RN positions, and 79% for the LVN positions. From a review of the Facility's nursing staffing data and discussions with the CNE, since the last review, the Nursing Department had continued to experience staffing challenges, and in January 2014, began using agency nurses to decrease overtime and assist in retention of current nursing staff. Some of the recruitment activities implemented included newspaper and radio advertisements. In addition, the CNE reported that 10 student nurses would be coming to CCSSLC for a clinical rotation that could possibly lead to future employment potential. As previously recommended, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. Quality Enhancement Efforts Since the last review, the Program Compliance Nurse, the QA Nurse, the Infection Control Nurses, and the Nurse Educators had continued using the flowing nursing Health Monitoring Tools: ▪ Annual Nursing Summary; ▪ Nursing Care Plan Monitoring Tool; ▪ Hospital/Infirmary Prevention Tool; ▪ Urgent Care; ▪ Integrated Progress Notes; ▪ Nursing Protocol Spot Check; ▪ Spot Check Form (Medication Observation); ▪ Emergency Equipment Competency; ▪ Emergency Cart Checklist; ▪ Infection Control Real Time Audits; ▪ Case Manager Reviews; and ▪ QA Nurse Audits.	

#	Provision	Assessment of Status	Compliance
		At the time of the review, establishing inter-rater reliability was in process for the tools shared by the PCM and the QA Nurse. In addition, the Facility had made significant progress regarding added instructions to the current Health Monitoring tools. In another positive step forward, the Facility indicated that it was beginning to include the use nursing protocols in the instructions for the HMTs when assessing the quality of the nursing services and documentation. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> However, consistent with the Monitoring Team's findings from past reviews, there was little evidence found in the IHCPs or acute care plans or in the overall nursing documentation reviewed that the nursing protocols were being used to drive the identification and implementation of the specific nursing assessments, provide clear and appropriate timeframes for initiating nursing assessments and the type of assessments that should be conducted, assist in determining the frequency of these assessments, and/or identify the parameters and time frames for reporting symptoms to the practitioner/physician and PNMT, if indicated, regarding individuals with acute changes in health status. When nursing assessments were completed, it was only in response to an acute issue, indicating that an individual with existing health conditions or diagnoses had to become ill in order for nursing to implement assessments. A review of 10 individuals' IPNs (i.e., Individual #141, Individual #239, Individual #340, Individual #130, Individual #252, Individual #183, Individual #205, Individual #44, Individual #3, and Individual #79) who had been transferred to a community hospital, emergency room, and had been in the Infirmary found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in alignment with the nursing protocols for none of the individuals (0%). ▪ The documentation indicated that the licensed nursing staff timely and consistently informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. Due to the lack of ongoing clinically appropriate nursing assessments, changes in status were only identified when the individual was already acutely ill. ▪ The documentation indicated that appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse consistently performed appropriate ongoing assessments as dictated by the symptoms in alignment with nursing protocols in none (0%) of the cases. ▪ The nurse conducted assessments at the appropriate frequency for the individual's clinical condition in alignment with the individuals' overall medical status in none (0%) of the cases. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in alignment with the nursing protocols addressing the specific health issue in none (0%) of the cases. ▪ The documentation indicated that all acute illness/injuries were followed through to resolution in none (0%) of the cases.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team did note that there were more IPNs that contained an adequate nursing assessment than found during previous reviews. However, the lack of consistency of the nursing assessments rendered the overall care of the individuals insufficient to address their specific needs. Although the IPNs indicated that some nursing protocols had been implemented, although not consistently, after the individuals demonstrated symptoms of an acute illness, there were no nursing protocols implemented regarding the existing high and medium health risks these individuals already had experienced. There was no indication they were being used consistently to guide nursing assessments and documentation. As noted in previous reports, the Facility should continue to implement and expand the use of nursing protocols to guide nursing practices for existing health conditions. The Facility's Self-Assessment indicated that it was not in compliance with these elements of this requirement, which was consistent with the Monitoring Team's findings. <u>Availability of Pertinent Medical Records</u> From a limited review of records while on site, it was noted that very few documents were missing from the active records. However, the Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. <u>Infection Control</u> From the Facility's Self-Assessment, a review of the documentation contained in the Presentation Book addressing Infection Control, as well as interviews with the IC Nurses, review of the documentation, and information gathered during the review, since the last review, additional positive steps forward had been made regarding the process of building an infrastructure to meet the requirements of the Settlement Agreement related to infection control. Some of the progress noted included: ▪ The Facility continued to implement the process addressing data reliability to ensure the Facility's trends related to infectious and communicable issues were accurately identified. From data generated by comparing the Infection Control Reports, Infection Control Logs from the residences, and the Pharmacy reports for the utilization of antibiotics, the following compliance percentages reflected data reliability checks for Infection Control: 97%, 100%, 100%, 99%, 100%, and 98% from August 2013 through January 2014, respectively. These data reflected consistent compliance regarding the accuracy of the overall IC data. ▪ During the previous review, the Facility had instituted the ImmTrac, the Texas Immunization registry offered through the Department of State Health Services. ImmTrac was a secure and confidential registry available to all Texans. It consolidated and stored immunization information electronically in one centralized system. Participation required written consent and limited access to the Registry to only those individuals authorized by law. Only authorized professionals such as doctors, nurses, and public health providers could access individuals' vaccination histories. The IC Nurse reported that at the time of the review, 97%	

#	Provision	Assessment of Status	Compliance
		of the individuals had had consent obtained and were registered. ▪ Since the last review, the Facility had begun discussing the findings of the Real Time Audits at the Monthly RN meetings. ▪ Since the last review, the documentation contained on the Outbreak Reports continued to be detailed, and included specific clinical information regarding the individuals' status and progress, as well as any treatments initiated and precautions implemented. In addition, it indicated the IC Nurses provided a number of timely in-service training sessions to staff in response to the outbreaks and followed all cases reported to resolution. ▪ The content of the minutes of the Infection Control Committee meetings continued to improve, including the content of the information, analysis, and issues discussed to address some of the data generated from the IC Monitoring Tools. ▪ Based on the ISP schedule, the Facility continued to review individuals' complete immunization histories and update any needed laboratory work or immunizations, as appropriate. At the time of the review, 71% of the individuals had had their immunization information brought up-to-date. Although the IC Nurses made positive steps forward, a number of significant problematic areas regarding infection control continued to be in need of further attention, including: ▪ At the time of the review, the Facility recently had begun reviewing the Infection Control Environmental Checklists to ensure that the problematic issues identified on the tools had been timely and adequately addressed. This process should continue and this information should be used in conjunction with other IC data to identify any correlations between the problematic environmental issues and the Facility's rates of infections. ▪ With regard to nursing care plans addressing infectious illnesses, the documentation the Facility provided to the Monitoring Team indicated there had been eight individuals diagnosed with an acute infection (i.e., Individual #335, Individual #144, Individual #79, Individual #205, Individual #356, Individual #3, Individual #340, and Individual #304). Of the eight individuals, seven (88%) were found to have had HMPs addressing the infectious issue. Individual #79 did not have a care plan addressing the infectious illness. Of the seven Nursing Care Plans reviewed, two were found to be clinically adequate (29%), including those for Individual #335 and Individual #3. This is discussed in more detail with regard to Section M.3. The Facility should develop and implement a system to ensure the care plans for individuals with infectious/communicable disease are timely completed, clinically appropriate, and consistently implemented. Clearly, the Facility had made some positive steps forward regarding the system addressing Infection Control issues. However, some of the consistent problematic areas, such as the lack of care plans and the inadequate care plans regarding infectious illnesses, need to be addressed in order for substantial gains to be made in meeting the requirements of the Settlement Agreement. As noted in previous reports, consideration should be given to providing the Facility with additional expertise and technical assistance in Infection Control to assist in effectively operationalizing the infection control	

#	Provision	Assessment of Status	Compliance
		systems in alignment with IC standards of practice and the Settlement Agreement, as well as providing professional feedback regarding the quality and completeness of the infection control program. <u>Mock Code Drills and Emergency Response Systems</u> Since the last review, positive steps CCSSLC had made regarding this area included: ▪ The Facility continued to review the daily Emergency Cart Checklists verifying that the daily Emergency Cart checks were being done consistently to ensure that the equipment was available in case of an emergency situation. ▪ The Facility's review of the monthly nursing Emergency Competency skills checklist data from August 2013 through January 2014 showed the following compliance rates: 90%, 96%, 97%, 100%, 97%, and 97%, respectively. ▪ The Nursing Educators continued conducting spot checks of emergency equipment use and oxygen flow rates. The Monitoring Team's observations of nurses demonstrating the emergency equipment at the Infirmary and Sand Dollar found that the nurses observed were familiar with the use and operation of the Facility's emergency equipment. It was clear to the Monitoring Team that the consistent drills and spot checks regarding the emergency equipment were having a very positive impact in this area. ▪ Since the last review, the Facility had continued to expand its emergency drills to include a variety of emergency scenarios. ▪ In January 2014, the Facility conducted its first clinical review of the Mock Code Drills at the Nursing QA meeting. In addition, in February 2014, staff from the CTD and the Nurse Educators also met to review the Emergency Mock Code Drill data. The CNE reported that the data regarding the drills were difficult to interpret in its current format, and the CNE would be meeting with the QA Director, Data Analyst, CTD staff, and Nursing Educators to resolve the issue. As this process continues, it is anticipated that data regarding the actual medical emergencies (6333) that occur at the Facility will also be discussed. Since the last review, the data from the drills conducted were as follows: ▪ 17 drills conducted in August 2013 – 14 passed (82%); ▪ 19 drills conducted in September 2013 – 15 passed (79%); ▪ 18 drills conducted in October 2013 – 14 passed (78%); ▪ 17 drills conducted in November 2013 – eight passed (47%); ▪ 18 drills conducted in December 2013 – 11 passed (61%); ▪ 16 drills conducted in January 2014 – 11 passed (69%); and ▪ 17 drills conducted in February 2014 – 10 passed (59%). Clearly, the Facility had continued to take positive steps forward regarding CCSSLC's Emergency Response System. However, there continued to be problematic issues related to the requirements in Section M.1 of the Settlement Agreement. Based on the Monitoring Team's findings, the Facility remained out of compliance with this provision.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>M2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.</td><td>As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. CCSSLC indicated in the Facility's Self-Assessment that since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement:
▪ The Facility's Self- Assessment indicated that a review of Quarterly and Annual Nursing assessments from 8/1/13 through 1/31/14 to determine if they had been completed and filed in the Active Record within the month due found that 97% to 100% were timely completed, and 87% to 97% were filed in the Active Records.
▪ In addition, the Facility indicated that a review of the items listed below was conducted regarding the Annual/Quarterly Nursing Assessments using the Health Monitoring Tool (HMT) and the following was found (8/1/13 through 1/31/14):
<table><tr><th>Annual Assessment Tool</th><th>August 2013</th><th>September 2013</th><th>October 2013</th></tr><tr><td>N= total number of ISPs for the month.</td><td>23</td><td>19</td><td>22</td></tr><tr><td>n= actual number of HMTs audited</td><td>6</td><td>6</td><td>4</td></tr><tr><td>% S (Sample)</td><td>26%</td><td>32%</td><td>18.2%</td></tr><tr><td>Inter Rater Agreement</td><td>None</td><td>77%</td><td>72%</td></tr><tr><td>#AN.3r.i: Each nursing problem/diagnosis was identified, the reason for the diagnosis</td><td>0</td><td>17%</td><td>0</td></tr><tr><td>#AN.3r.ii: General approaches and interventions are summarized and incorporated into Section X. Nursing Summary/ Analysis in the Comprehensive Nursing Review form</td><td>17%</td><td>17%</td><td>0</td></tr></table>
In November 2013, State Office changed the monitoring tool, and this changed the items monitored:
<table><tr><th>Annual Assessment Tool</th><th>November 2013</th><th>December 2013</th><th>January 2014</th></tr><tr><td>N= total number of ISPs for the month.</td><td>15</td><td>15</td><td>19</td></tr><tr><td>n= actual number of HMTs</td><td>6</td><td>6</td><td>7</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

audited			
% S (Sample)	40%	40%	37%
Inter Rater Agreement	68%	68%	62%
4Gii: Health Risk (Current Risk Levels)	44%	38%	50%
4Iii: Integrated Health Care Plan Progress	11%	13%	0%

Although the presentation of data by the Facility had significantly improved, it was unclear to the Monitoring Team what specific criteria were used to determine compliance with each item presented. The sample sizes used were noted to be adequate. However, continued efforts were needed to increase the inter-rater reliability agreement in order to generate accurate data for these items.

Self-rating:
The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in substantial compliance. In November started a mentoring program for the Case Managers to review the Annual summary in comparison with the Integrated Risk Rating form (IRRF) and Integrated Health Care Plan (IHCP), this is in our Action Plan for M.2, step 4. Corrective action plans will be developed for systemic issues that are identified."

Although the Facility's finding of noncompliance was consistent with the Monitoring Team's findings, the reasons for the Monitoring Team's finding of noncompliance as noted below were based on specific findings related to the problems with the quality of the content of most of the Comprehensive Nursing Assessments. From a review of the nursing assessments below, it was clear to the Monitoring Team that the Facility was in the beginning stages of focusing its efforts on improving the documentation contained in the Comprehensive Nursing Assessments. Although not consistently found in most of the assessments the Monitoring Team reviewed, improvement was noted regarding the Summary Section in three of the Comprehensive Nursing Assessments reviewed. These improvements included the use of the past quarterly or annual information and comparing it to the current quarter/year, resulting in the completion of an adequate analysis of the individuals' health/mental health issues between quarters/years, and indicating if the health issues were improving, maintaining, or getting worse. However, due to the ongoing lack of implementation of the nursing protocols for existing conditions/diagnoses, appropriate clinical nursing assessments were not consistently being conducted for the individuals, and this resulted in an absence of objective clinical data generated to even allow analysis to occur.

The Quarterly/Annual Nursing Assessments for 20 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for Individual #122, Individual

#	Provision	Assessment of Status	Compliance
		#189, and Individual #86 for aspiration risk; Individual #348, Individual #238, and Individual #147 for behavior issues; Individual #79, Individual #275, and Individual #366 for constipation; Individual #369, Individual #268, and Individual #243 for falls; Individual #292, Individual #321, and Individual #290 for fractures; Individual #247, Individual #130, and Individual #239 for infections; and Individual #218, and Individual #78 for weight: ▪ Of the 20 individuals' nursing quarterly assessments reviewed, 20 (100%) were timely completed. ▪ There was an adequate analysis of the health/mental health data between the previous and current quarters in three (15%) of the Nursing Summaries contained in the Comprehensive Nursing Assessments to indicate if the individual was making progress related to their health/behavior issues (i.e., Individual #122, Individual #189, and Individual #86). ▪ There was an adequate assessment of the high and medium risk health indicators included in three (15%) of the Comprehensive Nursing Assessments (i.e., Individual #122, Individual #189, and Individual #86). ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. From interviews with the CNE, since November 2013, Nursing Administration had been meeting weekly with the Nurse Case Managers to review the nursing documentation and the IRRFs and IHCPs. These clinical discussions and mentoring meetings were a promising step forward in not only assessing the documentation, but also clinically reviewing cases. As the Monitoring Team previously recommended, appropriate competency-based training and mentoring regarding the Quarterly/Annual Comprehensive Nursing Assessments should continue to be provided to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. This area should be considered a priority for nursing. It is imperative that the nurses responsible for completing the quarterly/annual Comprehensive Nursing Assessments have the ability and understanding to analyze, summarize, and document health/mental health issues to determine whether the individuals under their care are actually making progress regarding their health/mental health status. Regarding the nursing documentation for individuals discharged/ transitioning to the community, a review of the nursing documentation and CLDP Comprehensive Nursing Reviews for four individuals including: Individual #313, Individual #318, Individual #87, and Individual #34 found the following: ▪ None (0%) of the CLDP Comprehensive Nursing Reviews adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would specifically guide the community staff in providing the needed nursing care to the individual. ▪ An adequate nursing assessment was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. ▪ There was adequate documentation identifying specific nursing interventions needed for all	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>health/mental health issues in none (0%) of the cases reviewed.

Since the last review, the Facility had added more documents to the transitions packets such as the immunization records, the IHCPs, and any Acute Care Plans. In addition, the nurse that trained the community providers used the packet as a training source and a copy was left with the provider after the training was provided. However, the poor quality of the added nursing documentation did not add to the information the community provider needed. As noted consistently in previous reports, it is crucial that CCSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individual's transition/discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care.

Consequently, the changes implemented had not resulted in any measurable improvement found in the nursing documentation for the individuals that had been transitioned to the community since the last review. Based on the Monitoring Team's findings, the Facility remained in noncompliance with this provision.</td><td></td></tr>
<tr><td>M3</td><td>Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.</td><td>As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. CCSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement:
▪ The Facility's Self-Assessment indicated that a review was conducted using the Annual Nursing Care Plans Health Monitoring Tool (HMT) for the Integrated Health Care Plans written for individuals who had an ISP from 8/1/13 to 1/31/14. Below were the Facility's findings:
<table>
<tr><th>Annual Nursing Care Plan Tool</th><th>August 2013</th><th>September 2013</th><th>October 2013</th><th>November 2013</th><th>December 2013</th><th>January 2014</th></tr>
<tr><td>N= total number ISPs due for the month.</td><td>23</td><td>19</td><td>22</td><td>15</td><td>15</td><td>19</td></tr>
<tr><td>n = actual number of IHCPs</td><td>6</td><td>6</td><td>4</td><td>6</td><td>6</td><td>7</td></tr>
<tr><td>% S (Sample)</td><td>26%</td><td>32%</td><td>18.2%</td><td>40%</td><td>40%</td><td>37%</td></tr>
<tr><td>Inter rater Agreement</td><td>n/a</td><td>87%</td><td>65%</td><td>75%</td><td>67%</td><td>56%</td></tr>
<tr><td>1. b. The IHCP addresses each health care need of the individual, including needs associated with</td><td>60%</td><td>83%</td><td>50%</td><td>89%</td><td>100%</td><td>67%</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

high-risk or at-risk health conditions to which the individual is subject							
1. c. Has been reviewed on a quarterly basis, and more often as indicated by the individual's health	0%	25%	0%	0%	0%	8%
1.d. Has been revised, as necessary, based on the clinical needs of the individual	100%	0%	50%	50%	83%	83%
3. There is evidence that nursing interventions were implemented promptly after they were developed or revised	80%	67%	83%	56%	25%	100%

Although the Facility had made significant progress regarding the presentation of their data, the Facility's findings were not in alignment with the findings of the Monitoring Team's noted below, especially regarding the clinical quality of the IHCPs/care plans.

- As promising steps forward, the Facility had implemented the Documentation Review Team and the Nurse Case Manager Weekly meeting to review nursing documentation including the content of the IHCPs and care plans.

Self-rating:
The Facility's Self-Assessment indicated that: "based on the findings of the self-assessment, this provision is not in compliance. We currently have an action plan for M.3 step 1 and 2 addressing the

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		review and mentoring of nursing care plans {NCP}. Corrective action plans will be developed for systemic issues that are identified." The records of 20 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #122, Individual #189, and Individual #86 for aspiration risk; Individual #348, Individual #238, and Individual #147 for behavior issues; Individual #79, Individual #275, and Individual #366 for constipation; Individual #369, Individual #268, and Individual #243 for falls; Individual #292, Individual #321, and Individual #290 for fractures; Individual #247, Individual #130, and Individual #239 for infections; and Individual #218, and Individual #78 for weight. Of the 20 individuals' IHCPs reviewed: ▪ All (100%) were found to have a care plan addressing their high or medium risk health/mental indicator found on the Facility's At-Risk List. ▪ None (0%) of the nursing interventions contained in the 20 care plans indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. In addition, none of the nursing interventions listed in the care plans reviewed were in alignment with the nursing protocols addressing the existing specific health issues. ▪ None (0%) of the 20 care plans were found to be clinically adequate. There was no indication that any types of nursing assessments were to be conducted addressing specific existing health issue in alignment with the nursing protocols. The overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual's health care needs. Nursing Protocols that were found in the IHCPs were only to be conducted in response to an acute event. ▪ None (0%) of the 20 care plans contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 20 care plans were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 20 care plans, validating the implementation of the interventions was not possible, rendering them inadequate guides for the provision of care. For example, generic interventions such as "encourage fluids" could not be substantiated as being implemented. Although the Facility had implemented the Documentation Review Team and the Nurse Case Manager Weekly meeting to review nursing documentation including the content of the IHCPs, the results of these reviews had not yet impacted the quality of the documentation found in the IHCPs the Monitoring Team reviewed. As these reviews continue, the Facility needs to ensure that any improvements discussed during the reviews should be made to the IHCPs through the appropriate Facility avenues (i.e., ISPAs to integrate new interventions into existing ISPs). It was very concerning to note the overall lack of progress in this area since the last review. Specifically, some of the problematic issues identified in the Facility's previous care plans were found in the current IHCPs including: ▪ The rationale for several risk levels on the Integrated Risk Rating forms did not consistently	

#	Provision	Assessment of Status	Compliance
		include the needed clinical justification to support the designated level. Consequently, it was often difficult for the Monitoring Team to determine the accuracy of some of the risk levels and the need for action steps addressing the health risks. ▪ Most of the goals listed in the IHCPs reviewed did not address the etiology of the health problem as an objective clinical area of focus to assist the team in developing action steps that were individualized. Consequently, many action steps found in the care plans did not address the underlying cause of the health issue and had no association with the goals listed. ▪ As noted above, none of the nursing action steps found in the IHCPs reviewed were in alignment with the clinical assessments required by the nursing protocols for the specific existing health issues. ▪ The action steps contained in the IHCPs did not consistently include specific information regarding who would implement the intervention, such as the RN, LVN, or Speech Therapist; how often they were to be implemented, such as on which shift if daily; consistent notation of where they were to be documented; how often they would be reviewed; and/or when they should be considered for modification. Unfortunately, many of the nursing action steps were generic, not measurable, and non-specific to the individual's health care needs. ▪ At the time of the review, the IHCPs reviewed were found to be clinically inadequate, lacked appropriate proactive action steps addressing the health indicator, and were not adequately individualized. ▪ The generic nature of many of the action steps contained in the IHCPs prohibited validation that the steps were actually being implemented. Although the Facility had initiated some promising steps regarding reviewing nursing documentation that included IHCPs, it is essential that the Facility address the lack of clinically adequate care plans for the individuals under their care. As previously recommended, the Facility should develop and implement appropriate care plans based on priority and risk for all the individuals at CCSSLC. Regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated there had been eight individuals diagnosed with an acute infection (i.e., Individual #335, Individual #144, Individual #79, Individual #205, Individual #356, Individual #3, Individual #340, and Individual #304). ▪ Of the eight individuals, seven (88%) were found to have had Health Management Plans addressing the infectious issue. Individual #79 did not have a care plan addressing the infectious illness. ▪ Of the seven Nursing Care Plans reviewed, two were found to be clinically adequate (29%), including those for Individual #335 and Individual #3. Although some improvement was noted in the two of seven care plans reviewed, considerably more work was needed to ensure that individuals with infectious diseases were being tracked, monitored, and provided care plans that included the appropriate infection control measures, and clinically appropriate interventions to prevent the spread of infections. Consistent with findings from previous	

#	Provision	Assessment of Status	Compliance
		reviews, Nursing Administration, in conjunction with the Infection Control Nurses should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. As noted in previous reports, in order for progress to be made regarding this provision of the Settlement Agreement, the Integrated Health Care Plans/Nursing Care Plans should: ▪ Be in alignment with interventions and assessments from the nursing protocols; ▪ Be individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and specific identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the interventions will be reviewed and by whom; and ▪ Accurately reflect the clinical needs of the individuals regardless of the format and system utilized for plans of care. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. With regard to this provision, CCSSLC's Self-Assessment indicated the following: ▪ The Facility's Self-Assessment included some promising graphs of data addressing a review of Integrated Progress Notes (IPNs) to determine if Nursing Protocols were being used for the following protocols: Antibiotic Therapy, Fall or Suspected Fall, Respiratory Distress-Aspiration, Vomiting, and Urinary Tract Infection. However, the Monitoring Team was not able to interpret or determine the significance of the data due to the lack of information regarding the overall population (N), which would reflect the sample size audited, along with the lack of or low percentages of inter-rater reliability reported. In addition, the Facility's audits of nursing protocols were based on only those protocols that were implemented in response to an acute event. At the time of the review, there were no audits conducted regarding the ongoing use of nursing protocols for existing conditions or diagnoses. <u>Self-rating</u>: Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that: "based on the findings of the self-assessment, this provision is not in compliance. In October we began a mentoring group to review protocols and in January included the nurse in this process. We currently have an Action plan in place for M.4 steps 2 and 3 and will develop corrective action plans as systems issues are identified." Overall, the data presented in the Facility's Self-Assessment for this area was much clearer than noted in past reviews. However, the procedure described for initiating and auditing nursing protocols	Noncompliance

#	Provision	Assessment of Status	Compliance
		continued to only be based on the occurrence of an acute event, and not when there was an existing health issue requiring nursing assessments in alignment with nursing protocols. Consequently, the Facility's current practice regarding nursing protocols only reinforced reactive care rather than proactive care. Auditing just the Facility's reactive care does not usually capture the entire clinical picture of care provided to an individual, from the identification of a change in status to the resolution or need for ongoing assessments in alignment with the health issue and the nursing protocol. Regarding nursing documentation, although there were more entries found in the IPNs from nursing than during previous reviews, ongoing adequate clinical nursing assessments in alignment with the nursing protocols for the particular health issues the individuals were experiencing were not found in the documentation. Unfortunately, the additional documentation that was found did not actually result in an improvement in clinical care. The Monitoring Team did find some mention of nursing protocols in a few of the IHCPs that were reviewed. However, all of the nursing assessments listed in the nursing protocols were included in the plans for implementation only after an acute health event occurred, rather than proactively for individuals with existing high and medium health risks in an attempt to prevent the occurrence of an acute health event. The practice of only using nursing protocols reactively means that an individual has to become ill in order to be provided regular nursing assessments in alignment with the protocols, and only for as long as the acute event persists. Consequently, only implementing nursing protocols reactively does not result in improved clinical care focused on minimizing individuals' existing health risks. At the time of the review, the reactive use of nursing protocols found in some of the IHCPs reviewed did not result in an improvement in clinical care. The problematic findings found in the nursing documentation reviewed for Section M.1 regarding nursing care for individuals admitted to a community hospital, Section M.2 regarding most of the nursing assessments, Section M.3 regarding nursing care plans, and Section M.5 related to individuals with high-risk health indicators demonstrated that the Facility clearly was not implementing nursing protocols sufficiently to address the health status of the individuals served as required by this provision of the Settlement Agreement. In addition, these major concerns, especially those related to individuals with high/medium risk health indicators and their changes in status warranting hospital admissions, were exemplified in a review of ten individuals who had been hospitalized since the last review: Individual #141, Individual #239, Individual #340, Individual #130, Individual #252, Individual #183, Individual #205, Individual #44, Individual #3 and Individual #79. Specific details are provided with regard to Section M.1. In summary, a review of these individuals' records indicated the following: ▪ There was no indication that nursing was actually using nursing protocols as part of a structured system to guide nursing practice and the associated documentation; ▪ Clinically appropriate nursing assessments were not conducted for significant health issues	

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		and documented at the appropriate clinical frequency; ▪ Clinical baseline data had not been established to quickly recognize changes in health status; ▪ Timely communication had not occurred with practitioners/physicians or other disciplines regarding changes in status; and ▪ Appropriate and clinically adequate care plans had not been developed and implemented that outlined specific nursing interventions for specific health issues. These consistent problematic findings clearly showed that the Facility had not actually implemented the use of nursing protocols as required by the Settlement Agreement. Consistent with past reviews, the problematic findings from this review indicated that CCSSLC continued to fail to adequately and timely address the health care needs of the individuals residing at the Facility. The Facility indicated that it was not in substantial compliance with this requirement, which was consistent with the findings of the Monitoring Team.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. In response to this requirement, CCSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ The Facility indicated that a review of assessments submitted within 10 working days found 92% compliance rate. However, the Self- Assessment did not address the timeframe of the assessments, such as the last six months, of if the quality of the documentation was also assessed in determining compliance for this area. ▪ In addition, the Facility indicated that an increase in the number of change of status (CoS) ISPAs and increases in risk ratings demonstrated that the teams were more accurately identifying CoS and making the appropriate risk rating changes in response to them. <u>Self-rating</u> The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in substantial compliance. The data supports that nursing is performing an interdisciplinary assessment in a timely manner. With continued mentoring the IDT's [sic] have improved on identifying CoS and data reveals this. Action plan in place and Step 1 – 3 have been completed and will develop corrective action plans as systems issues are identified." Consistent with past reviews, the Monitoring Team's findings noted below indicated that much of the documentation reviewed did not adequately address individuals' health/mental clinical health risks in alignment with the requirements of this provision. A review of the most current quarterly or annual Comprehensive Nursing Assessments for 20 individuals determined to be at risk (i.e., Individual #122, Individual #189, and Individual #86 for aspiration risk; Individual #348, Individual #238, and Individual #147 for behavior issues; Individual #79, Individual #275, and Individual #366 for constipation; Individual #369, Individual #268, and Individual #243 for falls; Individual #292, Individual #321, and Individual #290 for fractures;	Noncompliance

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		Individual #247, Individual #130, and Individual #239 for infections; and Individual #218, and Individual #78 for weight) found that three (15%) included an adequate assessment of the specific high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form (i.e., Individual #122, Individual #189, and Individual #86). From a review of these nursing assessments, it was clear that the Facility was in the process of focusing its efforts on improving the documentation contained in the Comprehensive Nursing Assessments. Although not consistently found in all the assessments the Monitoring Team reviewed, improvement included using some of the past quarterly or annual information and providing an update regarding the current status of the health risk indicators. However, overall more work was needed regarding the analysis of the information contained in the Comprehensive Nursing Assessment. A review of these 20 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. As noted with regard to Section I, the Monitoring Team found that there was an overall increase in some of the specific clinical information contained on the IRRF forms. However, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, and falls, injuries and/or fractures, there was a lack of individual-specific information from the current year as compared to the previous year that made it difficult to determine the accuracy of the risk rating that was assigned. In addition, a review of the 20 records for these individuals determined to be at risk found there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). Although all 20 individuals were found to have an Integrated Health Care Plan addressing their high or medium health/mental risk indicator in the Active Record, none sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 20 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some ISPs addressing, for example, the need to encourage adequate fluids and exercise, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%).	

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Integrated the IHCP into the ISPs in 20 of the 20 cases (100%).
None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs.
None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan.
None of the plans (0%) included the specific clinical indicators to be monitored.
The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability, or it was not addressed.

At the time of the review, the Facility was continuing to implement the revisions that had been made to the ISP and At-Risk process, as well as focusing efforts on improving the quality of the Comprehensive Nursing Assessments and to improve the nursing information available for at-risk individuals in the IRRF. Continued efforts were needed regarding the individual-specific information contained in the IRRFs from nursing, including comparison of data from the current year to the previous year. More work also was needed to improve the quality of the interventions contained in the IHCPs to ensure they were in alignment with nursing protocols,
At the time of the review, the Facility indicated that it was not in compliance with this subsection of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.
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<tr><td>M6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly</td><td>
As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. In response to this requirement, CCSSLC's Self-Assessment indicated that since the last review, activities addressing this provision included the following:

The compliance data for the Medication Administration Observations from 8/1/13 through 1/31/14 for nurses indicated the following:

<table>
<tr><th></th><th>August 2013</th><th>September 2013</th><th>October 2013</th><th>November 2013</th><th>December 2013</th><th>January 2014</th></tr>
<tr><td>N= total number of Medication Pass Observation Audits completed each month</td><td>12</td><td>23</td><td>42</td><td>31</td><td>40</td><td>14</td></tr>
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</td><td>Noncompliance</td></tr>
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identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.

n = number of nurses who passed the medication audit	11	21	40	29	38	14
Overall Medication pass score (%) for Campus	92%	91%	95%	94%	95%	100%

Although the Facility indicated that their data regarding Medication Administration Observations showed the Facility was in substantial compliance for a six-month period, the number of unreconciled medications the Facility's data showed that the Pharmacy and Nursing Departments had identified over the review period indicated there were problematic issues regarding medication administration that the observation data had not captured, particularly for the months of August through November 2013. In addition, the Facility reported that in October 2013, medication administration observations were increased for three months as a plan of correction resulting from an ICF/IDD survey finding.

- The Facility's Self-Assessment noted that Medication Administration Spot Checks were newly implemented, and they provided additional oversight. The Facility reported that the data presented below indicated that problems were found on the spot checks reflecting noncompliance in this area.

Nurse Educator Medication Pass Spot Checks Campus	**December 2013**	**January 2014**
N = total number of Spot Checks completed	12	8
n = Number of nurses that passed	11	6
Percentage of passing competencies	92%	75%

- Regarding Blanks on the Medication Administration Records from 8/1/13 through 1/31/14, the Facility data indicated the following:

	August 2013	**September 2013**	**October 2013**	**November 2013**	**December 2013**	**January 2014**
Total Campus wide Medication Administration Blanks	81	166	161	132	134	135

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Percent of completed MAR to approximately 130,000 medication doses given	99.94%	99.87%	99.87%	99.90%	99.90%	99.90%

The Facility's Self-Assessment stated: "Although we stress that the only acceptable number of MAR blanks is zero, we are compliant 99.9% of the time for the 130,000 medication doses distributed."

- In addition, the Facility's Self-Assessment indicated that since the last review, nursing had assumed responsibility in November 2013 for the medication excess/shortage forms. This had allowed the Nurse Managers to investigate all unknown excesses and shortages in their buildings. Once an investigation was completed and the reason for the excess or shortage was not clarified, the medication variance was then assigned to the Nursing Department and designated as a Wrong Dose or Omission. The Facility's Unreconciled Medications data from 08/01/2013 through 01/31/2014 reflected the progress that had been made in identifying unknown excesses and shortages of medications:

	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014
Short Unknown	0	0	0	25	14	0
Excess Unknown	172	153	223	92	13	0

Regarding the Facility's self-rating, the Self-Assessment stated: "based on the findings of the self-assessment, this provision is not in substantial compliance. Nursing, Medical and Pharmacy continue to work as a team to identify and correct medication issues as they are identified. We currently have an Action plan in place for M.6 continue [sic] to work on step 2 and will develop corrective action plans as systems issues are identified."

In addition to the information that was provided in the Facility's Self-Assessment, interviews with the CNE and the Pharmacist indicated that since the last review, the Facility had initiated the following steps regarding the Facility's overall medication administration system:

- As noted during the previous review, the CNE had conducted a time study in response to a deficiency found by regulatory regarding medications not given within the required timeframes on Coral Sea. The findings of this study indicated that for a unit that had 54 individuals for whom medications were administered via G or J Tube, it took 17 minutes to administer medication to one individual, thus, the CNE reported that 12 additional LVNs

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		were needed to administer medications timely and safely. At the time of the review, the Facility had added a third medication room to the Coral Sea unit and was in the process of reviewing the reallocation of nursing positions to meet the needs of the individuals regarding medication administration. In addition, since the last review, in October 2013, the Facility increased the number of medication nurses at Coral Sea from four nurses to six nurses on the day and evening shifts. Also, in January 2014, the number of medication nurses was increased from four to five on day and evening shifts at Ribbonfish. ▪ Also in October 2013, new color-coded Excess/Shortage forms were implemented to easily identify which home generated the form. ▪ In December 2013, the Medication Variance Committee began tracking individuals who received Diastat for seizures, and reported monthly regarding the excess and shortages of medications that had not been reconciled. ▪ The Facility began the process of reviewing the unknown excess medications regarding seizure medications and found that one individual might have had an increase in seizure activity related to excess medications variances. ▪ In January 2014, the Facility began tracking medication variances from the Medical Department to be included in the overall Facility medication variance data. ▪ The Facility had arranged and stocked each medication room and cart in a consistent manner to avoid confusion and possibly delays for the nurses when they passed medications at different homes. Although the steps forward discussed above included some promising interventions, at the time of the review, the Monitoring Team found that CCSSLC continued to have some significant problematic issues regarding its overall medication administration system as noted below: ▪ As noted in previous reports, the Facility's data continued to indicate a high percentage of compliance regarding the Medication Administration Observations conducted. However given that the Facility's data indicating a significant number of unexplained medications were being returned to the pharmacy from August 2013 through November 2013, the high compliance scores regarding the Medication Administration Observation data continued to be suspect. However, there was no indication at the time of the review that nursing was analyzing these obvious discrepancies between data and practice. ▪ At the time of the review the Facility had begun the process of determining if the unexplained excess or shortages of medications had any impact resulting in changes in status for the individuals. It was positive that the Facility was having the Clinical Pharmacist attend the Morning Medical Meetings, and the Facility should continue to formally review the types of medications being returned to the pharmacy and any clinical impact it might be having on the individuals involved. These discussions should be consistently documented in the minutes of the meeting. ▪ Although the Facility was spending much time reconciling the number of unexplained returned medications each month, the number of actual medication variances consisting of	

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		medication given to the wrong person, at the wrong time, or the wrong dose, or the wrong route, or the wrong medication given, suggested that CCSSLC continued to have issues regarding the under-reporting of medication variances. ▪ The Facility's data indicated that there continued to be a significant number of MAR blanks indicating a breech in appropriate medication administration procedures of initialing the MAR upon administration of the medications. This coupled with the unreconciled and omission medication variance data reflected that nurses were not executing the accepted standard of practice regarding medication administration. A review of the medication variances (Category A-E) the Facility reported indicated the following (variance data included unreconciled excess and shortages): ▪ August 2013 – 199 variances; ▪ September 2013 – 171 variances; ▪ October 2013 - 238 variances ▪ November 2013 – 134 variances; ▪ December 2013 - 53 variances; and ▪ January 2014 - 63 variances. Based on observations of medication administration at the Infirmary, the following problematic issues were found. Specifically, the nurse did not: ▪ Know why Individual #179 was in the Infirmary and after referring to a census sheet, reported he recently had had surgery. However, she was not able to state the type of surgery he had. ▪ Listen to Individual #179's lung sounds in spite of the fact that he was on Hospice care related to chronic respiratory compromise, was taking Morphine which decreases respiratory status, and had a history of aspiration and aspiration pneumonia. The nurse stated that lungs sounds would only be obtained if triggers such as coughing were present. ▪ Clarify the exact position for medication administration on the PNMP for Individual #8 who had a fracture of the left femur. The PNMP stated both the "most upright position" as well as "30 degrees in bed." ▪ Know how to determine that the foot of Individual #8's bed was elevated 15 degrees since no measurement was marked or designated on the bed. ▪ In addition, the room that Individual #333 who had a fractured right hip was in was found to be extremely hot. The direct support professional was wiping sweat off of his face when the Monitoring Team members entered his room. The Assistant Director of Programs was alerted to this issue and the temperature was readjusted immediately upon notification. Infirmary staff should have resolved this issue rather than the Monitoring Team to ensure Individual #333 was in a safe environment. Although the Facility had made steady progress regarding the medication variance system issues,	

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		there continued to be problematic issues noted regarding the medication administration systems at CCSSLC. At the time of the review, the Facility was continuing to make positive steps forward regarding reviewing and implementing strategies to address some of the problematic elements of the medication administration system. As recommended in previous reports, the Facility should continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement actions aimed at long-term resolutions. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data, such as continuing to conduct regular reviews of the Medication Administration Records, and review the discrepancies between data sets including the Medication Administration Observations. Continued collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a format and structure to critically review the overall medication system. The Monitoring Team found the Facility was not in compliance with this provision. The Facility's finding of noncompliance in its Self-Assessment was consistent with the Monitoring Team's finding.	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of pharmacy services, including for updated policies, highlights of the approved changes; o Any pharmacy surveys completed since the last Monitoring Team visit: plans of correction and/or internal auditing procedures and reports related to pharmacy services; o List of staff who work in the Pharmacy Department, including names, titles, and degrees; o All Drug Utilization Evaluation (DUE) reports completed since last Monitoring Team visit, including background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results; o Any follow–up studies completed for any prior DUE reports; o Minutes of Pharmacy and Therapeutics (P&T) Committee meetings and any attachments since the Monitoring Team's last visit; o Minutes of any committee addressing medication error/variance since the Monitoring Team's last visit; o DUE calendar for next 12 months, including whether calendar based on fiscal year or calendar year; o For Quarterly Drug Regimen Reviews (QDRR), for all individuals the Facility serves, a listing of the individuals, their review periods, the dates in which reviews must be completed, and the dates on which reviews are actually completed for the last one year period; o For QDRR one most recent per residential home that has been completed with physician signatures and dates, with contents including anticholinergic justification, documentation or document (with date) of risk/benefit analysis completed in relation to side effects; and for polypharmacy justification, document (with date) in which rationale was discussed for polypharmacy for psychotropic and non-psychotropic polypharmacy including those for: Individual #48, Individual #90, Individual #296, Individual #300, Individual #314, Individual #276, Individual #299, Individual #70, Individual #256, and Individual #214; o For five most recent QDRR in which recommendations were made and accepted, copies of physician orders, for following individuals: Individual #166, Individual #354, Individual #174, Individual #335, and Individual #331; o For the following most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement, including those for: Individual #244 and Individual #295; o All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team visit; o Since the last Monitoring Team review, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system);

	○ For the past six months, any Adverse Drug Reaction (ADR) reports completed; ○ Training documentation concerning ADRs for past six months for new employees, training specific to health professionals (e.g., medical, pharmacy, nursing) in addition to the new employee training, and any training documentation of annual refresher training; ○ Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors; ○ Number of medication errors/ variances per month for prior six months by error type, nurse, home, shift, unit, individual, category of severity, error mode, including graphs, charts (i.e., per month, per quarter), and analysis reports, as well as corrective action plans, root cause analysis summaries, etc., for the past six months, number of medication variances per month per severity category (A-E). For the past six months, number of excess returned medications per month, number of true omissions per month, number per month due to blanks in Medication Administration Record (MAR). For the past six months, number of medication variances per department (i.e., medical, pharmacy, dental, nursing) per month; ○ Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors; ○ Copy of any communication between Pharmacy and Nursing Department concerning medication errors/variance (emails, memos, etc.) since the Monitoring Team's last visit; ○ For the past two months, reports and/or summaries of any medication administration observations conducted; ○ Any policies, procedures and/or other documents addressing medication administration; ○ List of antibiograms per month for last six months by building; ○ Medication history for individuals with J or G/J tubes (not G tubes); ○ A schedule of when QDDR are conducted by residence; ○ All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual #253 (8/1/13 at 1715hr), Individual #58 (8/8/13 at 1507hr), Individual #7 (8/10/13 at 1346hr), Individual #118 (8/12/13 at 1315hr), Individual #58 (8/20/13 at 1630hr), Individual #147 (8/26/13 at 1315hr), Individual #321 (9/5/13 at 1530hr), Individual #5 (9/9/13 at 2120hr), Individual #58 (9/11/13 at 0030hr), Individual #141 (9/24/13 at 1100hr), Individual #238 (10/10/13 at 1420hr), Individual #147 (10/28/13 at 1505hr), Individual #27 (11/30/13 at 0800hr), Individual #27 (11/30/13 0840hr), Individual #237 (12/6/13 at 135hr), and Individual #40 (12/10/13 at 1932hr); ○ Any trend analysis of chemical restraint use (i.e., graphs, etc.); ○ For each database maintained on use of chemical restraints, summary list(s) of all chemical restraints administered over the last six months, with the name/source of the database clearly identified; ○ For five new orders involving drug-drug interactions, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if

	applicable), and snapshot/screenshot verifying change in order received by pharmacy, copy of pharmacy label or MAR indicating pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following five individuals: Individual #200, Individual #278, Individual #79, Individual #338, and Individual #331; o For five new orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label or MAR indicating pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #146, Individual #122 (2/19/14), Individual #122 (1/30/14), Individual #278 (2/3/14), and Individual #278 (1/31/14); o For four new orders in which labs were reviewed/monitored, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label or MAR indicating pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #101, Individual #318, Individual #88, and Individual #253; o For one new order for which there was potential for significant side effects, copies of serial computer screen shots for each step, including any written documentation/ information provided to the PCP and response of the PCP. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by Pharmacy, or copy of pharmacy label or MAR indicating pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individual: Individual #24; o For QDDR, for all individuals the Facility serves, a listing of the individuals, their review periods, the dates in which reviews must be completed, and the dates on which reviews are actually completed for the last one-year period; o For the self-assessment process: list of monitoring/audit tools used and for each tool, identification of the total number of the eligible population to be sampled, the sample size, clarification how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process: list of databases utilized (other than audit information),

	including title of each database/chart/table with date range of each database. When the data was collected periodically rather than continuously, the frequency of data collection was requested; and o Presentation Book for Section N. ▪ **Interviews with**: o Gary Frech, RPH, Director of Pharmacy; o Jennifer Lynne Thompson, RPH, PharmD; and o Amy Isaacs, RPH, PharmD. ▪ **Observations of**: o Pharmacy and Therapeutics Committee, on 4/1/14; and o Medication Committee, on 4/2/14.
	Facility Self-Assessment: For Section N, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the new order review audit tool, QDRR assessment audit tool, and QDRR laboratory audit tool. o These monitoring/audit tools included some indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators or measurement indices that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews, review of computerized order entry databases, and use of various Avatar databases. o The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Clinical PharmD. o Adequate inter-rater reliability had been established between the PharmD and the QA nurse. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be complete and accurate. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Provided findings in table format; o Presented findings consistently based on specific, measurable indicators; and o Consistently measured the quality as well as presence of items. This was a new addition

	to the auditing tools. Not only whether the order was written, but the audit assessed whether or not the component(s) were in place, for instance. ▪ The Facility rated itself as being in compliance with the following sections: N.2, N.3, N.4, N.5, and N.7. This was not consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the need for improvement in complete orders being written. Some areas needed further review, such as the identification of abnormal lab values with recommendations based on these findings. The following describes some of the specific self-assessment activities in which the Pharmacy Department was engaged: The Pharmacy Department completed an internal QA review of the new order process. The audit tool entitled "QA Tool for New Order Review" was expanded to include two additional areas of monitoring (i.e., the type of order entry error and whether all necessary parts of the prescription were present). Instructions for using this expanded audit tool were revised on 3/17/14. The sample consisted of one new order for each residence per week. From nine to 12 new orders were audited weekly with the goal of 40 new orders reviewed per month. The sample was selected by reviewing every fifth new order in each residence per week. Weeks in which audits occurred included the week of August 5 to 9, 2013, through the week of January 20 to 24, 2014. An audit completion guideline was entitled "Instructions/Guidelines for Using New Order Entry QA Tool." This included eight components, each with one or more subcomponents in reviewing the new order entry. The eight components included the following: drug-drug interactions, allergies/sensitivities, drug dose/duration, side effects, labs, drug-disease contraindications/appropriateness of medication, route of administration, and necessary part of prescription present. It appeared that all the audits had been completed in January 2014 (i.e., date of signature of audit pharmacist). The Pharmacy Department indicated a new schedule for monthly reviews was started in February 2014. Data for new order processing was presented at the 4/2/14 Medication Committee meeting. These components were tracked from August 2013 through January 2014. Data indicated that compliance with these categories ranged from 67 to 89 percent. The category needing most improvement was the "parts of order present" category. The most recent information for February 2014 was also available, in which compliance was 63 percent. For these two months, the parts of orders not present included the route of administration, the indication for use, and the duration of therapy. At the January 30, 2014 P&T Committee meeting, members discussed the pharmacy process in documenting new orders with potential concerns. A summary of steps to be taken was documented in "Guidelines for Reporting Pharmacists' Interventions in the WORx System." It included a step-by-step process in documenting discussion with the PCP concerning the new order. A "PCP order Intervention Evidence List" was created to track these according to the type of concern: drug-drug interaction, allergic reactions, drug dosage concerns, review or monitoring of lab, and potential significant side effects. This should identify new orders that could be used to provide evidence of the pharmacy process. Also

developed was a one-page check sheet that listed many of the components reviewed for Section N.1.

The Pharmacy Department completed an audit of the lab tests and values reviewed on the QDRRs. For each month, 15 QDRRs were reviewed. The sample selection was determined by choosing every fifth individual on the QDRR schedule. Data was collected for August 2013 through January 2014. A document entitled "CCSSLC Medical Care, Psychotropic and Anti-epileptic drug monitoring/Matrix" was used in guiding the auditing pharmacist in completion of the audit. The monitoring tool indicated the name of individual, date of QDRR, the medication requiring monitoring, labs required, whether these labs were completed, and pharmacist comment. Through January 2014, this audit had been completed, but not on a routine monthly schedule. The Pharmacy Department indicated a monthly schedule was started in February 2014. An analysis of data was included in the Self-Assessment for the months completed (August 2013 to January 2014). Instructions for use of the audit tool were revised on 1/28/14.

The Pharmacy Department developed an internal QA monitoring audit tool to review timeliness of review of chemical restraint use by the pharmacists. The following information provided a review of the data collected to determine timeliness of review. It was noted that the seven-day window of review measured by the pharmacy is less than the 14-day window that the Monitoring Team uses to measure compliance.

Month	Number of Chemical Restraints	Number of Chemical Restraints Reviewed	Number of Reviews Completed in 7 Days	Number Reviews Completed >7 Days	Percentage Compliance
August 2013	6	6	5	1	83%
September 2013	4	4	3	1	75%
October 2013	2	2	2	0	100%
November 2013	4	4	4	0	100%
December 2013	2	2	1	1	50%
January 2014	0	NA	NA	NA	NA

The Pharmacy Department audited every chemical restraint in the Avatar Medical Record System to determine timely completion by the pharmacist.

The Pharmacy Department had implemented an auditing tool to determine whether specific components of the QDRR had been completed. Each month, 15 QDRRs were reviewed (i.e., every fifth individual listed on the QDRR schedule). Contents of the monitoring tool included the following topics reflecting the contents

	of the QDRR: atypical antipsychotic indication, benzodiazepine, anticholinergic, polypharmacy, metabolic and endocrine risk, lab monitoring, Monitoring of Side Effects Scale (Moses), Dyskinesia Identification System: Condensed User Scale (Discus), timeliness, whether recommendation was made, whether the PCP agreed with the recommendation, and if the PCP disagreed, whether justification was documented. For some of these headings, the indicator was not clearly written (for instance, for the heading benzodiazepine, did this refer to whether it was prescribed, whether the prescription was justified, or whether there were side effects or drug interactions noted?). These were not done monthly. A new schedule of a monthly review was to be started February 2014.
	Summary of Monitor's Assessment: Since the Monitoring Team's last visit, the Pharmacy Department had added two clinical PharmDs, which should assist in more rapid movement towards substantial compliance. The Pharmacy and Therapeutics meetings had updated information and encompassed the spectrum of pharmacy concerns. The medication variance category of unknown excess returns appeared to have been nearly eradicated, due to numerous steps the Pharmacy Department had taken. There was a system in place, with database development in process, to track individuals with seizures to determine if medications were missed for any reason. The adverse drug reaction process appeared complete with evidence of training appropriate staff from several departments, as well identification of adverse drug reactions, and reporting of analysis for further discussion at the P&T meetings. The drug utilization evaluation process appeared to be mature, and a system was in place to conduct follow-up of prior DUEs. The new order process needed strengthening. A new PharmD noted the lack of essential components while completing a detailed audit. The submission of evidence for various types of new order categories had remained a challenge in achieving compliance. A system needed to be in place for the Pharmacy Department to complete timely review of chemical restraints. For Quarterly Drug Regimen Review completion, the Pharmacist needed to address abnormal lab values with comments or recommendations. The Primary Care Practitioners needed to meticulously respond to any recommendations in a timely manner. As the reasons for medication variances become identified, the Pharmacy Department is encouraged to continue to implement new system processes to support its own staff and the Nursing Department in reducing such occurrences. The Facility was in substantial compliance with Sections N.5, N.6, and N.7.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of	The Pharmacy Department staffing included the following: a Director of Pharmacy, three other staff pharmacists (i.e., two full-time and one part-time), and three certified pharmacy technicians. "Patient intervention" entries for new orders entered into the WORx software program were submitted for review for the 60-day time period from 12/23/13 to 2/19/14. There was one patient intervention report for December 2013, 24 patient intervention reports for January 2014, and 17 patient intervention reports for February 2014. Interventions were broken down into several different categories. Based on data the Facility provided, the numbers of patient	Noncompliance

#	Provision	Assessment of Status	Compliance
	each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	interventions for each category follows: **Category of Intervention** / **December 2013** / **January 2014** / **February 2014** Drug Interaction Identified: 1 / 6 / 7 Medication Monitoring: 0 / 4 / 4 Route/Dosage Form Change: 0 / 2 / 0 Pharmaco-economics: 0 / 0 / 1 Dose Adjustment: 0 / 0 / 2 Allergy/adverse drug event/effect: 0 / 1 / 0 Pharmacokinetics: 0 / 1 / 0 No categorization: 0 / 10 / 3 **Total per month**: **1** / **24** / **17** A sample of 15 new prescriptions was reviewed. The following summarize the results: ▪ Five new orders were submitted in which the Pharmacy found concerns with **drug-drug interactions** with the current drug regimen. A copy of the order was submitted in five of five. A computer screen shot of the order process, label, or Medication Administration Record (MAR) was submitted for five of five. For five of five, a copy of the patient intervention form was submitted. A change in the order occurred in five of five orders. Evidence indicated compliance in five of five new orders. ▪ No new orders were submitted in which **allergies** were reviewed and determined by Pharmacy to be a concern. Pharmacy indicated that when an allergy is determined when processing the order, communication occurs promptly and the order is then not processed, but discontinued. However, documentation of this process is necessary to provide evidence of correct processes the Pharmacy had in place. Based on the data submitted regarding patient interventions, there had been at least one related to allergies. This section could not be further evaluated due to lack of information. ▪ One new order was submitted in which **significant side effects** was reviewed by Pharmacy and determined to be a concern. This included a copy of the order, a copy of the label verifying the correct processing of the order, copy of the patient intervention, and plan documented in the patient intervention report. Evidence for compliance occurred in one of one new order. However, this was an inadequate sample size. Given the number of medications the Pharmacy processed, there clearly were many medications for which the Pharmacy reviewed side effects prior to completing the order. It is recommended that each component of the document request be reviewed, and a file of applicable orders with appropriate evidence be collected as the processes occur. This section could not be reviewed due to insufficient evidence. ▪ Four new orders were submitted in which **current laboratory results and potential need for further testing** were identified by Pharmacy during initial review. A copy of the	

#	Provision	Assessment of Status	Compliance
		screen shot or equivalent was submitted in one of four. A copy of the patient intervention was submitted in four of four. Orders for follow-up testing were in place or were written for three of four. Lab data was submitted in three of four. Documentation was adequate in one of four. It was noted that three of the four orders were continuation orders and not new orders. This became problematic when one of the steps to provide the necessary evidence is to copy the new order to show the Pharmacy is accurately processing the order (i.e., Section N.1 is specifically related to new orders). It is important to select new orders in which the complete process can be readily demonstrated. ▪ Five new orders were submitted in which pharmacy had concerns about the potential need for **dosage adjustments**. For five of five orders, there was a copy of the original order. For two of five, there was a screenshot, label, or MAR that matched the new order process. For one, the order chosen for review was from 1/31/14, but the MAR was from 1/22/14. For one new order, no evidence was submitted (i.e., screenshot, label, or MAR). For one new order, the order dated 2/3/14 was followed by an MAR for the medication dated 2/8/14. There appeared to be a missing MAR for the date of the 2/3/14 order. A copy of the patient intervention was submitted in four of five orders. One patient intervention report was dated 2/3/14, and it was used as evidence in processing the 1/31/14 order as well as the 2/3/14 order for the same medication. A change of order based on Pharmacy review and PCP contact occurred in four of five, and a change of order was submitted in four of five. Based on the evidence submitted, documentation was adequate in two of five new orders in this sample. In summary, there was adequate documentation of the process in nine of 15 submitted new orders. Adequate numbers of new orders were submitted for three of five new order subsections. Additionally, the Pharmacy chose ongoing orders as new orders rather than new orders not associated with continuation orders in a number of examples which, made collection and interpretation of evidence a challenge. The Facility remained in noncompliance with this subsection.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A schedule of completed QDRRs was submitted for September 2013 through January 2014. Each of the prior QDRRs was reviewed for date of completion and compared to the current due date for completion. For this time period, 385 of 401 (96%) QDRRs were completed in a timely manner. For the more recent months of October 2013 through January 2014, 325 of 325 (100%) QDRRs were completed in a timely manner. QDRRs were considered completed in a timely manner determined by the agreed upon time period. This time period was based upon a due date that was set for every 90 days, with additional parameters established as a time period of seven days prior to the due date through 13 days after the due date for the QDRR to be considered timely. A sample of 10 QDRRs was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 10 QDRRs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ For 10 of 10 (100%) QDRRs, the lab results included exact values or indication of normal range for Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin (Hgb) A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (most commonly noted were antiepileptic drug levels with therapeutic ranges). ▪ Ten of 10 (100%) QDRRs had the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab for two out of seven (29%) for which this was applicable. For three no abnormal lab values were recorded. ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated that the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. The Facility was found to be in noncompliance with this provision. QDRRs needed to include comments on abnormal lab values to facilitate the prescribing practitioners' follow-up.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the	This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for 16 chemical restraints used from August through December 2013. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that 12 individuals had 16 chemical restraints during this time period. For the 16 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 16 chemical restraint forms, 16 (100%) forms included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in three of the 16 (19%) chemical restraint forms completed. ▪ Side effects, adverse effects, and drug-drug interactions were noted in 16 (100%) of the completed chemical restraint forms. ▪ There were five statements that were considered recommendations. ▪ The range of time for completion of 15 chemical restraints was from one to 171 days. There was one wrong entry (date recorded preceded the date of event) for the date completed by Pharmacy, and timeliness could not be determined for this one QDRR.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>use of new generation antipsychotic medications.</td><td>
To review the Psychiatry Department's review of chemical restraints, the Facility submitted Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for five most recent chemical restraints used from 12/6/13 to 3/10/14. The identifying information for those five episodes of chemical restraints is as follows:
<table>
<tr><th>INDIVIDUAL</th><th>DATE</th><th>TIME</th><th>MEDICATION</th></tr>
<tr><td>Individual #253</td><td>3/10/14</td><td>4:04 pm</td><td>Zyprexa 25mg IM</td></tr>
<tr><td>Individual #40 (A)</td><td>3/1/14</td><td>6:45 pm</td><td>Zyprexa 10mg IM</td></tr>
<tr><td>Individual #50</td><td>2/23/14</td><td>10:09 am</td><td>Ativan 2mg IM
Benadryl 25mg IM
Haldol 5mg IM</td></tr>
<tr><td>Individual #40 (B)</td><td>12/1013</td><td>7:32 pm</td><td>Zyprexa 10mg IM</td></tr>
<tr><td>Individual #237</td><td>12/6/13</td><td>1:25 pm</td><td>Zydis 10mg PO</td></tr>
</table>
The chemical restraint documentation indicated that four individuals had a total of five chemical restraints from 12/6/13 through 3/10/14. The Psychiatrist had a designated space for completion of the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. Because of Avatar's multiple screen form completion process, the Pharmacy completed their section prior to the Psychiatry section being completed. This allowed the Psychiatrist to scroll through and review the Pharmacy information. Review of these documents showed:

Of the five completed, there were five (100%) forms on which the psychiatry comment section was completed. The Psychiatrist had reviewed the context for the chemical restraint, as well as the effects of the intervention. The Pharmacy section was completed for four (80%) of these individuals, but could not be found in the materials related to Individual #237.
For five of five (100%), clinical justification was documented.
Side effects were mentioned in five of five (100%) reviews. However, the physiological post-restraint monitoring portion of the documentation was adequately completed for only one (i.e., Individual #40A) of the five individuals in this sample (20%). This section of the documentation for the episodes of chemical restraint for Individual #253 and Individual #40B did not contain monitoring data. The data related to Individual #5 and Individual #237 contained data related to vital sign monitoring, but did not have adequate documentation regarding the mental status.
There were five statements that were considered recommendations.

<u>Polypharmacy</u>
Of the 10 QDRRs reviewed, polypharmacy was noted in three reviews.
</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in three of three (100%). ▪ Clinical justification for the use of polypharmacy was addressed in three of three (100%). ▪ Potential interactions with other drugs or food/side effect risk was reviewed in three of three (100%) ▪ For three of three (100%), the QDRRs provided evidence whether monitoring/evaluation had occurred of effectiveness and appropriateness of the drug regimen. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in zero of the 10 QDRRs. <u>Anticholinergic Monitoring</u> Of the 10 QDRRs, 10 (100%) were screened for medications associated with potential significant anticholinergic side effects. Four QDRRs identified anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in four of four (100%) cases with this medication prescribed; ▪ Four of four (100%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect (i.e., the clinical burden of the side effects was less than the benefit). ▪ Four of four (100%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 10 QDRRs reviewed, three listed atypical antipsychotic medication. Of these, three (100%) included lab values that reviewed endocrine and metabolic risks (i.e., Basic Metabolic Panel (BMP), glucose level, Hgb A1C, and/or lipid panel as appropriate). Due to concerns related to the reviews completed of "stat" medications, the Facility remained out of compliance with this provision.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record	Review of 10 QDRRs showed the following: ▪ Of the 10, 10 (100%) QDRRs had the PCP signature. ▪ Of the 10, nine (90%) had the date the PCP reviewed the document. ▪ There were three recommendations from the 10 QDRRs. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in one of three (33%). There was no information recorded for agreement or not for two of three recommendations. ▪ The PCP responded within 14 days of the QDRR being completed by pharmacy in seven of 10 QDRRs. Response was over 14 days in two QDRRs and not dated in one QDRR. ▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication. A psychiatrist reviewed three of 10 QDRRs.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>a clinical justification why the recommendation is not followed.</td><td>

Agreement was documented in one of three. For two of three, there was no recommendation.
Disagreement with justification and plan was not indicated for psychiatry to complete in any of the three QDRRs.
The psychiatrist responded within 14 days of the QDRR being completed by pharmacy in one of three QDRRs.

To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted five active records in which recommendations were made on the QDRR. These are listed above in the documents reviewed section. In the sample of five, five (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation.

The Facility submitted two active records in which recommendations from the QDRR were not followed, which are listed in the documents reviewed section. In two of two cases (100%), the response, rationale, and plan were written on the QDRR.
</td><td></td></tr>
<tr><td>N5</td><td>Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.</td><td>The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.</td><td>Substantial Compliance</td></tr>
<tr><td>N6</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow-up remedial action regarding all significant or unexpected adverse drug reactions.</td><td>The Facility continued to train new employees on the curriculum for “Observing and Reporting Clinical Indicators of Health Status.” This curriculum included information concerning drug reaction signs and symptoms. The submitted information included training rosters/sign in sheets for last day of attendance. The following training indicated the number of staff that completed training per month (employee training per department was not provided):
<table>
<tr><th>Month</th><th>Number of new employees trained according to Roster completed for “Observing and Reporting Clinical Indicators”</th><th>Number of new employees trained based on Sign-in sheet for last day of new employee orientation</th></tr>
<tr><td>August 2013</td><td>35</td><td>35</td></tr>
<tr><td>September 2013</td><td>31</td><td>31</td></tr>
<tr><td>October 2013</td><td>22</td><td>27</td></tr>
<tr><td>November 2013</td><td>40</td><td>42</td></tr>
</table>
</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

December 2013	38	39
January 2014	29	29

According to the Pharmacy Department, 100 percent of new employees completed ADR training.

Evidence was submitted indicating training for the following new nursing staff had occurred on the subject of adverse drug reactions (document entitled "Adverse Drug Reaction"):

Month	Number of Nurses Trained	Month	Number of Nurses Trained
August 2013	9	September/October 2013	3
November 2013	5	December 2013	5
January 2013	20	**Total**	**42**

Evidence was submitted indicating completion of refresher training for adverse drug reactions in the course entitle: "Observing and Reporting Clinical Indicators of Health Status Changes."

Date	Number Trained	Date	Number Trained
1/15/14	86	1/16/14	111
1/17/14	123	Undated	37
Total trained in refresher course	**357**		

Separately, the Pharmacy Department provided in-service training information for annual refresher training of clinical staff. The breakdown per month was as follows:

Department	9/13	10/13	11/13	12/13	1/14	2/14	3/14
Medical	0	0	0	0	0	0	5
Psychiatry	0	0	0	0	0	0	1
Pharmacy	0	0	0	0	0	0	3
Dental	0	0	0	0	0	0	2
Nursing	9	51	7	1	10	12	0

Total clinical staff completing the annual refresher training by Pharmacy was 101.

The following table represents data extracted from the ADR reports and information submitted by the Pharmacy Department for the prior six months:

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Date</th><th>Medication</th><th>Reaction</th><th>Date Notified Pharmacy</th><th>Naranjo ADR Problem Scale</th><th>ADR Reported to Med Watch</th><th>Added to Allergy Profile/Drug Alert</th></tr>
<tr><td>11/12/13</td><td>Testosterone</td><td>Physiological</td><td>11/12/13</td><td>7</td><td>No</td><td>Yes</td></tr>
<tr><td>3/13/14</td><td>Bactrim</td><td>Dermatology</td><td>3/14/14</td><td>2</td><td>No</td><td>No</td></tr>
<tr><td>12/3/13</td><td>Bactrim</td><td>Dermatology</td><td>12/3/13</td><td>2</td><td>No</td><td>No</td></tr>
</table>

In summary, the process appeared to be effective in identifying and analyzing potential adverse drug reactions. There was good collaboration with the medical staff in determining if the adverse drug effect was reportable, and whether it represented an allergy that would be added to the medication profile of the individual.
</td><td></td></tr>
<tr><td>N7</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.</td><td>At the December 2013 P&T Committee meeting, a DUE calendar was approved. This included the following:
Niacin/Lovaza (first quarter);
Calcium carbonate (second quarter);
Folic acid (third quarter); and
Glucosamine chondroitin (fourth quarter).
Alternates were also suggested by committee members, including: Co enzyme Q 10, Paliperidone, and Topiramate.

DUE follow-ups included:
Latuda (first quarter);
Proton-pump inhibitors (second quarter);
Niacin/Lovaza (third quarter); and
Calcium carbonate (fourth quarter).
During the prior six months, two DUE studies were completed:
At the 1/30/14 P&T Committee meeting, a DUE was presented for the use of non-statin cholesterol medications. The prescribing of Niacin, Lovaza, Fenofibrate, and Gemfibrozil were reviewed. Most individuals reached blood levels of low-density lipoprotein and total cholesterol consistent with goals. Recommendations included consideration of decreasing or discontinuing use of these medications. The DUE was noted to be thorough with review of adverse effects of each medication discussed, as well as a comparison of effect on lipid panel results among statin and non-statin cholesterol medications. A consensus guideline for treatment of cholesterol was also included. A table of various statin medications comparing dosages to attain similar lowering of cholesterol levels was included.</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		▪ At the 2/2014 P&T Committee meeting, a DUE data collection form was presented. This DUE was for calcium supplement. A copy of the audit tool was provided. It included the dosage of the calcium, the indication for the calcium, whether there was Vitamin D ordered, whether a multi vitamin was ordered, whether osteoporosis or osteopenia if present was being treated, whether the individual was receiving a proton pump inhibitor, if other medications were prescribed at the same time, and whether the individual had end stage renal disease. The summary of collected information was discussed at the 4/1/14 P&T Committee meeting. Recommendations included assessing the average calcium intake in the diet (calcium from dietary sources is recommended). It was recommended that calcium citrate should be prescribed when an individual was taking a proton pump inhibitor rather than calcium carbonate, except for those requiring a liquid form. ▪ At the 2/2014 P&T Committee meeting, a follow-up DUE data collection form was presented for proton pump inhibitors. This included indication for the medication, comorbid conditions, other GI medications, whether specific supplements were prescribed, whether serum magnesium was on the chart, whether bisphosphonates were prescribed, and whether there was a hospitalization or gastrointestinal bleed in the prior two years. Collected follow-up information was presented at the 4/1/14 P&T Committee meeting. Focus was on duration of therapy, appropriate dosing, and safety concerns. Recommendations included checking magnesium levels periodically for those on long-term treatment, use of calcium citrate (a finding also noted in the prior DUE), and use of lowest effective dose for the shortest duration of time in those with mild GERD. ▪ At the 1/30/14 P&T Committee meeting, a DUE follow-up was reviewed. The medication reviewed was Latuda. Focus was on the appropriate indication for prescribing the drug, whether it was administered with meals, and whether monitoring parameters were in place. The follow-up DUE indicated that there was a trend toward use for labeled indications from the prior DUE. There was a continued recommendation to order this medication with a meal to improve absorption. Monitoring parameters for metabolic effects were considered adequate. Based on this information, within four days of this DUE presentation, there was a change of orders to administer Latuda with meals in nine individuals. This indicated a significant clinical impact of this quality DUE. The Facility was found to be in substantial compliance with this subsection. The drug utilization evaluation (DUE) process appeared to be mature, and a system was in place to conduct follow-up of prior DUEs. A calendar was available for DUEs in 2014.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one	<u>Policies and Procedures regarding Medication Variances</u> Since the Monitoring Team's last visit, policies that were approved and implemented included the following: ▪ "Pharmacy Services and Safe Medication Practices N.13. Medication Excess/Shortage	Noncompliance

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	year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances.	Forms Preparation/Processing," approved 3/5/14, and implemented 3/5/14; ▪ "Pharmacy Services and Safe Medication Practices N.14. Medication excess/shortage forms preparation/processing (for all homes except Infirmary, Sand Dollar, and Sea Horse)," approved 3/15/14, implemented 3/5/14; ▪ "Pharmacy Services and Safe Medication Practices N.15. Medication Fill and Delivery Process (for Infirmary, Sand Dollar, and Sea Horse)," approved 3/5/14 and implemented 3/5/14; ▪ "Pharmacy: Transportation of Drugs Under Proper Conditions of Sanitation N.11," implemented 1/31/14; ▪ "Pharmacy: Processing Medication Excess and Shortage Forms N.11," draft 12/30/13; ▪ "Pharmacy: Medication Fill and Delivery Process (for Infirmary, Sand Dollar, and Sea Horse) N.11," draft 2/24/14; and ▪ "Pharmacy: Medication Fill and Delivery Process (for all homes except Infirmary, Sand Dollar, and Sea Horse) N.11," draft 2/24/14. <u>Committee Monitoring of Medication Errors/Variances</u> The minutes of the Medication Committee meetings were reviewed to determine Facility's progress in the development and implementation of a medication error process and trend analysis. Since the Monitoring Team's last visit, the committee met on 10/30/13, 12/18/13, and 1/22/14. The Medication Committee also met on 4/2/14, the week of the Monitoring Team's visit. Additionally, the Pharmacy and Therapeutics Committee met on 12/17/13, 1/30/14, and February 2014 (exact date not included in P&T Committee minutes). This P&T Committee also met on 4/1/14, during the week of the Monitoring Team's visit. The following describes some of the findings of this committee: The number of medication variances per department were provided per month:	

Month	Pharmacy Department	Nursing Department	Medical Department	Dental Department	Total
September 2013	16	155	0	0	171
October 2013	10	228	0	0	238
November 2013	15	119	0	0	134
December 2013	17	36	0	0	53
January	24	39	0	0	63

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2014					
February 2014	4	84	0	0	88
Total	**86**	**661**	**0**	**0**	**747**

The number of medication variances per month were categorized by severity:

Month	Category A	Category B	Category C	Category D	Category E
September 2013	16	0	155	0	0
October 2013	10	0	228	0	0
November 2013	10	1	123	0	0
December 2013	17	0	36	0	0
January 2014	24	0	39	0	0
February 2014	5	1	81	1	0
Total	**82**	**2**	**662**	**0**	**0**

The Pharmacy Department indicated there were no errors greater than Category D. However, during a death review, there was indication of a medication error(s) that led to increased monitoring followed by hospitalization. The lack of root cause analysis in determining the actual steps leading to this event was concerning, and is discussed in further detail with regard to Section L.2. It was not clear if Pharmacy reviewed the categorization of this medication error, or if it was re-categorized from a Category C to a Category F. Once an investigation occurred, it did not appear it was further reviewed for accurate categorization by Pharmacy. It is recommended that a monitoring system be implemented by Pharmacy to ensure accurate categorization of errors.

The Pharmacy Department provided the following description of major categories of medication variances per month:

Month	Excess Unknown Returns (Doses)	Unknown Shortage (Doses)	MAR Not Initialed	Documented Omission
September 2013	153	0	166	1
October 2013	223	0	159	4

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November 2013	92	25	131	2
December 2013	14	13	134	9
January 2014	0	0	135	23
February 2014	0	1	151	6
Total	**482**	**39**	**876**	**45**

Additional Pharmacy Monitoring Processes

To further reduce the number of medication variances, the Pharmacy Department designed and implemented a number of systems in collaboration with the Nursing Department, as needed. The Pharmacy Department provided a list of action steps taken to reduce medication variances since the Monitoring Team's last visit. These included the following steps:

- As part of the medication placement process, doses were checked against the MAR/Cart Fill List by both pharmacy and nursing staff. Any discrepancies were resolved at that time. This had greatly reduced the unknown shortages.
- The use of the Medication Excess and Shortage Form was color coded by Unit, with creation of ample supply of these forms when needed, without the nurse having to copy the forms.
- Patient returns to Pharmacy were credited weekly instead of monthly.
- The nurse managers investigated the unknown excess returns and shortages during the following week of the variance.
- Additional medication rooms were added to the residences with the highest utilization of medications and nursing services. Specific residences also used a three-day/four-day medication cart for the drug distribution system.
- Nursing shift count of medication was implemented.
- To assist with accurate medication administration, the Pharmacy supplied oral liquid medication in dose cups or syringes, and per dose.
- Pharmacy services expanded to a six-day per week service to be more readily available to nursing staff.
- Floor stock was refined to meet the needs of each residence, rather than being identical across campus.
- The Pharmacy Department began tracking seizure activity with missed medications or unknown returned medications. A form was created to document the information. This was entitled "Medication Variance review of seizure information." For the individual being reviewed, this listed the seizure activity for each month for the prior year, the dates of seizures in the month currently being reviewed, the dates of Diastat use, and date and number of doses of anti-epileptic medications returned. This was completed for two

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		individuals and presented at the January 2014 Medication Committee meeting, and for five individuals at the April 2014 Medication Committee meeting. <u>Medication Error Reports</u> Copies of the last 10 medication variance reports were submitted for review. The Monitoring Team member reviewed and classified the medication variances according to the State Office policy/guideline. There were zero Class A medication errors, one Class B medication error, nine Class C medication errors, and zero Class D medication errors. Nursing had classified the errors as zero Class A medication errors, six Class B medication errors, three Class C medication errors, and one was not classified. Eight different medications were involved in these 10 medication variances. Four of 10 involved seizure medication. Three were transcription errors, two were wrong doses, one was the wrong time, and four were known errors of omission. Follow-up of the errors was documented in 10 of 10 errors. It is recommended that the Pharmacy Department review a sample of medication variance reports for accuracy, completeness, and agreement with categorization definitions. <u>Medication Observation Monitoring</u> Nurse educators routinely completed medication pass assessments/medication administration observations across campus on a monthly basis. From 12 to 42 medication passes were observed per month from August 2013 through November 2013. The pass rate was 92 to 97 percent. The most recent data indicated 100 percent compliance in January 2014, and 85 percent compliance in February 2014. Additionally, spot check audits were conducted eight to 12 times per month. Compliance was 63 to 92 percent. The most recent data indicated 75 percent compliance in January 2014, and 72 percent compliance in February 2014. These reviews are discussed in more detail with regard to Section M.6. In summary, the pharmacy needs to audit the categorization of medication variances to determine accuracy of nursing assessment. Medication variances that occur within days of a death or hospitalization/ER visit need intensive focused review to determine any potential impact of the medication variance. As the causes of the medication variances are determined (with reduction in unknown returned excesses), systems need to be created by pharmacy to assist the Nursing Department in tracking specific causes of medication variances, and offer additional support structures to reduce or prevent the occurrence of repeat events.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Presentation Book for Section O; o The following documents for 15 individuals in Sample O.1 (i.e., Individual #130, Individual #3, Individual #58, Individual #315, Individual #17, Individual #9, Individual #327, Individual #128, Individual #19, Individual #243, Individual #194, Individual #252, Individual #179, Individual #134, and Individual #191): Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of Interdisciplinary Team members required to attend the annual ISP meeting, ISP Preparation Meeting documentation, Occupational Therapy/Physical Therapy comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment/tool, Speech Language Pathology comprehensive assessment, SLP assessment of status, SLP update, Head of Bed Elevation (HOBE) assessment, annual ISP and ISP Addendums for past year, Integrated Risk Rating form, IDT Risk Action Plan/Integrated Health Care Plan, Integrated Progress Notes (IPNs) for past six months, OT/PT/SLP/Registered Dietician (RD) consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan and dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post-Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management (PNM) foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMT Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o The following documents for six individuals in Sample O.2 (i.e., Individual #340, Individual #335, Individual #356, Individual #333, Individual #138, and Individual #153) on the PNMT caseload who were assessed or reviewed in the last six months: Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of IDT members required to attend the annual ISP meeting, ISP Preparation Meeting documentation, PNMT assessment, PNMT action plan and supporting documentation, HOBE assessment, APEN assessment/tool, annual ISP and ISPAs for past year, IRRF prior to referral to PNMT, IRRF completed by PNMT and IDT upon referral, Integrated Progress Notes for past six months, Aspiration Trigger Sheets for past six months, PNMP and dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse

	reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post-Hospitalization assessment, Nursing Care Plan/Integrated Health Care Plan, documentation of staff successfully completing PNM foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress related to PNM difficulties, and PNMT Discharge and supporting documentation; o The following documents for seven individuals in Sample O.3 (i.e., Individual #130, Individual #58, Individual #9, Individual #327, Individual #194, Individual #179, and, Individual #134): OT/PT comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, APEN assessment/tool, SLP comprehensive assessment, SLP assessment of status, SLP update, HOBE assessment, annual ISP and ISAs for past year, Integrated Risk Action form, IDT Risk Action Plan/Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/RD consultations for past year, Aspiration Trigger Sheets for past six months, PNMP and dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing PNM foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o PNMPs for the following 47 individuals: Individual #179, Individual #8, Individual #333, Individual #128, Individual #222, Individual #181, Individual #77, Individual #134, Individual #150, Individual #244, Individual #67, Individual #19, Individual #287, Individual #10, Individual #304, Individual #3, Individual #45, Individual #367, Individual #282, Individual #376, Individual #228, Individual #315, Individual #194, Individual #210, Individual #110, Individual #224, Individual #326, Individual #263, Individual #136, Individual #159, Individual #291, Individual #200, Individual #103, Individual #65, Individual #214, Individual #308, Individual #184, Individual #379, Individual #56, Individual #132, Individual #278, Individual #181, Individual #366, Individual #307, Individual #207, Individual #93, and Individual #146; o List of Physical and Nutritional Management Team members and curriculum vita; o List of all individuals seen by the PNMT; o List of all individuals the PNMT assessed and the date of assessment; o List of all individuals the PNMT discharged; o Physical Nutritional Management Policy and Procedure; o List of continuing education sessions in which PNMT members participated; o Agenda, curriculum, attendance rosters, and certificates of completion for PNMT staff;

	○ Minutes and documentation of attendance for PNMT meetings; ○ List of changes in PNMT evaluation form; ○ Policy and procedures addressing identification of PNM health risk levels, including criteria for establishment of risk levels; ○ List of individuals with PNM needs; ○ List of individuals without PNM needs; ○ Wheelchair/Mobility/Assistive Equipment Work Orders; ○ Completed PNMPs and Dining Plans; ○ List of tools that PNMP Coordinators use to monitor staff compliance; ○ List of individuals for whom PNM monitoring tools were completed during last quarter; ○ Tools utilized for validation of competency of staff responsible for PNM monitoring; ○ Inter-Rater Reliability Scores; ○ Dining Plan (template) with changes; ○ PNM and PNMT-related database reports, and spreadsheets generated by Facility; ○ List of individuals on modified/thickened liquids; ○ List of individuals who require mealtime assistance; ○ List of individuals who receive nutrition through non-oral methods; ○ List of individuals whose diets have been downgraded or changed to a modified texture or consistency; ○ List of individuals with Body Mass Index (BMI) equal to or greater than 30; ○ List of individuals with BMI equal to or less than 20; ○ List of individuals who have had an unplanned weight loss of 10 percent or greater over a six-month period; ○ List of individuals who have had a choking incident during the past six months; ○ List of individuals who have had an aspiration and/or pneumonia incident during the past six months; ○ List of individuals who have had a fall during the past six months; ○ List of individuals who have had a decubitus/pressure ulcer during the past six months; ○ List of individuals who have experienced a fracture during the past six months; ○ List of individuals who have had a fecal impaction during the past six months; ○ List of individuals who are non-ambulatory or require assisted ambulation; ○ List of individuals with poor oral hygiene; ○ List of individuals who received a feeding tube since the last review; ○ List of individuals who are at risk of receiving a feeding tube; ○ List of individuals who have received a Modified Barium Swallow Study (MBSS) or other diagnostic swallowing evaluation during the past year; ○ Schedule of meals by residence; ○ Schedule of all PNM-related meetings occurring during the week of the Monitoring Team's onsite review; ○ Curricula on PNM used to train new staff responsible for directly assisting individuals; ○ Agenda and curriculum for competency-based, annual refresher training related to PNM; ○ List of completed PNMT Nursing Post Hospitalization Assessments/Evaluations;

	○ Quality Assurance/Quality Improvement meeting minutes related to PNM, PNMT, and the Habilitation Therapy (HT) Department; ○ Minutes from the HT Department meetings for the past six months; ○ External PNM consultant reports since the Monitoring Team's last review; ○ Changes to PNMP templates since the Monitoring Team's last review; ○ QA/QI Quarterly Section Review for Section O; ○ Number of new staff who successfully completed New Employee Orientation (NEO) PNM foundational performance check-offs (n), over number of staff in NEO over last six months (N); ○ Number of current staff who have successfully completed PNM performance check-offs (n), over number of current staff (N); ○ Number of current staff who have completed annual refresher training (n), over number of staff required to complete annual refresher training (N); ○ At-Risk Rating List; ○ List of approved trainers for NEO and annual refresher PNM foundational training; ○ List of approved trainers for PNM individual-specific training (i.e., non-foundational); ○ List of PNM monitors, and for each monitor listed, date of NEO training competencies completed, and check-offs completed for validation and inter-rater agreement; and ○ PNMT meeting minutes and attendance sheets completed after submission of pre-review document request. ▪ **Interviews with:** ○ Mary Wilcox, PNMT Coordinator, PNMT RN, Core Member; ○ Rosie Cortez, PNMT OT, Core Member; ○ Steve Strader, PNMT PT, Core Member; ○ Cynthia Spurgat, PNMT RD, Core Member; ○ Melissa Grothe, PNMT SLP, Core Member; and ○ Dana Verhey, Program Compliance Monitor, QA Department. ▪ **Observations of:** ○ Individuals in multiple residences, dining rooms, and day programs, including: Individual #179, Individual #8, Individual #333, Individual #128, Individual #222, Individual #181, Individual #77, Individual #134, Individual #150, Individual #244, Individual #67, Individual #19, Individual #287, Individual #10, Individual #304, Individual #3, Individual #45, Individual #367, Individual #282, Individual #376, Individual #228, Individual #315, Individual #194, Individual #210, Individual #110, Individual #224, Individual #326, Individual #263, Individual #136, Individual #159, Individual #291, Individual #200, Individual #103, Individual #65, Individual #214, Individual #308, Individual #184, Individual #379, Individual #56, Individual #132, Individual #278, Individual #181, Individual #366, Individual #307, Individual #207, Individual #93, and Individual #146; and ○ PNMT meeting, on 4/1/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, updated 3/14/14. In its

	Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. Based on a review of the Facility Self-Assessment for Section O, as well as interviews with the Director of HT, the following was found: ▪ The monitoring/audit tool the Facility used to conduct its self-assessment included: the Settlement Agreement Monitoring Tool for Section O. The quarterly monitoring results were presented at the QA/QI Council meeting to facilitate integration amongst the different Plan of Improvement sections. Based on interview, the Section O Monitoring tool was in the process of being revised. In addition, multiple Facility-developed audit tools (i.e., PNMT assessment, and PNMP audit tool) and HT database reports were implemented to assess compliance. ▪ The data presented in the Self-Assessment reflected the completion of additional activities and audits, such as tracking attendance at PNMT meetings, review of PNMT referrals, PNMT assessment and PNMP audit tool, etc. ▪ The monitoring and audit tools included adequate methodologies, such as observations, record review, and staff interview. ▪ The Self-Assessment identified the sample sizes used to complete audits. For a number of samples, the number in the sample (n) was identified in comparison with the total population size (N). ▪ The Settlement Agreement Monitoring Tool for Section O had instructions/guidelines to ensure consistency in monitoring and the validity of the results. However, the PNMT assessment audit tool did not have instructions, standards, and/or methodologies. ▪ The following staff/positions were responsible for completing the audit tools: The Director of HT, therapists, and a PCM. ▪ The Director of HT and the Facility Program Compliance Monitor continued to achieve a high level (i.e., exceeds 85%) of inter-rater agreement. ▪ The Facility used other relevant data sources, including, for example, NEO and annual refresher staff training databases; data related to IHCPs, PNMPs, and IRRFs; continuing education database; review of Facility PNM policies; etc. ▪ The Facility presented some of the data in a meaningful/useful way with the exception of not distinguishing data collected by the QA Department or the HT Department. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators; o Consistently measured the quality as well as presence of items; and o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section O. This was consistent with the Monitoring Team's findings. ▪ The Facility's data identified areas in need of improvement. The Director of HT and the Facility PCM provided an analysis of the Section O Monitoring results that identified the potential causes for the issues with plans to ameliorate noncompliance findings.
	Summary of Monitor's Assessment: The Facility's Physical and Nutritional Management Team had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. In

	addition to the need for further follow-up on systemic issues previously identified, PNMT meeting minutes should include reports on the status of individuals' clinical health indicators, to assess whether individuals are better or worse, and to analyze the efficacy of their interventions. Some individuals in Sample O.1, who met the PNMT referral criteria and should have been referred to the PNMT, were not. PNMT assessments continued to contain the majority of components necessary. However, additional work was needed to establish and/or review individual-specific clinical baseline data and to develop measurable outcomes related to individual-specific clinical indicators to assist teams in recognizing changes in health status and provide a methodology to measure whether or not the supports were effective. In addition, individuals' PNMT assessment recommendations had not been integrated into IHCPs. Individuals' Physical and Nutritional Management Plans did not include all of the necessary components. Interdisciplinary Teams were reviewing individuals' PNMPs at the annual meetings, but the ISPs did not include evidence of the teams' review of PNMP effectiveness as well as accuracy, updates/revisions agreed upon by the teams, and specified changes required with rationale. On a positive note, the Facility continued to implement a process that alerted staff to PNMP revisions and their responsibility in the implementation of an individual's PNMP when revisions had been made. During the Monitoring Team's onsite review, a member of the Monitoring Team, PNMT Occupational Therapist, Facility therapists, PNMP Coordinators, the Director of Residential Services, and the Unit Director for Ribbonfish completed mealtime and snack observations in Coral Sea and Ribbonfish. These observations occurred in dining rooms during lunch and/or dinner as well as an activity room where snacks were being presented. Multiple concerns were noted during these observations, which are discussed with regard to Section O.4. On a positive note, an observation of dinner in the Coral Sea dining room did not reveal any mealtime errors. For example, individuals were being brought to eat in different waves so that the dining room was not noisy and chaotic. Table captains did not leave the table during the mealtime. Staff were referring to the dining plans and were following the written instructions. This mealtime observation was similar to the mealtime observation that was completed at Coral Sea during the last review. The PNMT OT, Facility therapists, and two PNMP Coordinators completed observations of the implementation of PNMPs with a member of the Monitoring Team. Observations were completed in the Infirmary, the residences of Coral Sea and Ribbonfish, and day programs. These observations confirmed that staff continued to breach individuals' PNMPs. The Facility was providing physical and nutritional management foundational training during New Employee Orientation and annual refresher training. Individual-specific training was being provided to staff supporting individuals with needs beyond what the foundational training covered. However, the Monitoring Team was not able to discern from the documentation submitted if all required staff had

	successfully completed performance check-offs for individuals whose PNMP strategies required individual-specific training. Individuals in Sample O.1 and O.2 were not monitored for the effectiveness of their progress in relation to their physical and nutritional management needs, nor did the Facility provide evidence that interventions were modified if an individual was not making progress. More specifically, the implementation of individuals' IHCPs did not generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. Monthly progress notes were not completed to report on the effectiveness of individuals' supports and services, individuals' PNMPs and aspiration trigger data sheets did not have individual-specific triggers identified, and aspiration pneumonia trigger data sheets were not completed as required on a daily basis. The Facility maintained an updated list of individuals who received enteral nutrition. Individuals in the sample, who received enteral nutrition, were reviewed by their IDTs. However, the annual assessment did not include necessary elements.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The	As noted above with regard to the documents reviewed section, four samples were selected for the review of Section O. These included: ▪ **Sample O.1** consisted of a non-random sample of 15 individuals chosen from a list the Facility provided of individuals identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI issues, or osteoporosis], requiring mealtime assistance and/or prescribed a dining plan, at risk of receiving a feeding tube, and/or who had experienced a change of status in relation to PNM concerns (i.e., admitted to the emergency room, and/or hospital). Individuals within this sample potentially met one or more of the preceding criteria. These 15 individuals were: Individual #130, Individual #3, Individual #58, Individual #315, Individual #17, Individual #9, Individual #327, Individual #128, Individual #19, Individual #243, Individual #194, Individual #252, Individual #179, Individual #134, and Individual #191. ▪ **Sample O.2** consisted of four individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. This sample included four individuals: Individual #340, Individual #335, Individual #356, and Individual #333. Two additional individuals were added to the sample: Individual #138 and Individual #153. They had been discharged from the PNMT since the last review. ▪ **Sample O.3** was comprised of seven individuals who received enteral nutrition. These seven individuals were: Individual #130, Individual #58, Individual #9, Individual #327, Individual #194, Individual #179, and Individual #134. Some	Noncompliance

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	PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	of these individuals were included in one of the other samples. ▪ **Sample O.4** consisted of 47 individuals (i.e., Individual #179, Individual #8, Individual #333, Individual #128, Individual #222, Individual #181, Individual #77, Individual #134, Individual #150, Individual #244, Individual #67, Individual #19, Individual #287, Individual #10, Individual #304, Individual #3, Individual #45, Individual #367, Individual #282, Individual #376, Individual #228, Individual #315, Individual #194, Individual #210, Individual #110, Individual #224, Individual #326, Individual #263, Individual #136, Individual #159, Individual #291, Individual #200, Individual #103, Individual #65, Individual #214, Individual #308, Individual #184, Individual #379, Individual #56, Individual #132, Individual #278, Individual #181, Individual #366, Individual #307, Individual #207, Individual #93, and Individual #146) observed in the residences, dining rooms, and day programs. This included random, individual-specific observations, as well as observations of individuals in Sample O.1 and O.2. Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. The evaluations and planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the Settlement Agreement. In addition, Section O.1 specifically requires that: "The Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan (PNMP) of care consistent with current, generally accepted professional standards of care… The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team." The status of these requirements is discussed with regard to Section O.3. **PNM Policy and Role of the PNMT** As stated in the previous report, based on the Monitoring Team's review of Facility and State policies, the Facility had a comprehensive PNM policy, which included the following elements: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan; ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ Requirement that the development and implementation of an individual's PNMP	

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		shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ The composition of the Facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia (This was not stated specifically in the policy, but it was clearly in practice); ▪ A system of effectiveness monitoring; ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns, including: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Requirement that monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Providers meeting, QA/QI Council meeting); o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan); o Process to determine effectiveness of actions taken, and revision of	

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		corrective plans, as necessary; and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate, to measure the resolution of systemic issues; and ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk; o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide); o Identification of monitors and their roles and responsibilities; o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitoring; o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician; and o Frequency of monitoring to be provided to all levels of risk. **Core PNMT Membership** The CCSSLC PNMT had the appropriate disciplines as defined in the Settlement Agreement. PNMT members included a Registered Nurse, Physical Therapist, Occupational Therapist, Registered Dietician, and a Speech Language Pathologist. Although not a requirement of the Settlement Agreement, back-up members had been identified for each position. **Consultation with Medical Providers and IDT Members** The Facility reported the PNMT did not have any medical providers assigned as consultants to the PNMT. However, PNMT members stated that they had accessibility to medical providers (primary care physicians) and medical consultants if they had questions and/or needed guidance for individuals on their caseload. For four of the four individuals in Sample O.2 (i.e., Individual #340, Individual #335, Individual #356, and Individual #333) (100%), evidence was provided of medical providers' participation (i.e., primary care physician) in individuals' initial PNMT assessments. In addition, RN case managers attended meetings to provide updates for individuals on the PNMT caseload. The PNMT Meeting minutes provided updates from completed medical appointments and consultations. The RN Case Manager was able to	

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		communicate with the individual's primary care physician if questions arose during the meeting that could not be answered. In addition, the PNMT Nurse and/or a designee attended the daily provider morning meetings to receive current updates on individuals who had experienced a change in status. Every Friday morning, the PNMT Nurse also provided updates to members of the provider morning meetings on the status individuals on the PNMT caseload. For four of the four individuals (i.e., Individual #340, Individual #335, Individual #356, and Individual #333) (100%) in Sample O.2, evidence was provided of routine participation of other IDT members (i.e., QIDP, RN Case Manager, and Psychologist/Psychology Assistant) in meetings, review of assessments, and other needed activities. **Qualifications of PNMT Members** Five of five (100%) PNMT core members were licensed to practice in the state of Texas. Five of five (100%) PNMT core members had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Specialized training is defined as graduate education or continuing education content that is relevant to enhancing the provision of supports to individuals with identified PNM concerns. **Continuing Education** Five of five (100%) PNMT staff had completed continuing education directly related to physical and nutritional supports and transferrable to the population served within the past 12 months. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. ▪ PT attended: Issues in Healthcare Conference 2013 (8/13/13); ▪ SLP attended: Neurohabilitation Conference 2013 (5/18/13); ▪ OT attended: Neurohabilitation Conference 2013 (5/18/13), Pediatric Dysphagia: Management of the Whole Child (8/28/13), Texas Occupational Therapy Association 2013 Mountain Central Conference (11/7/13), and Annual Habilitation Therapies Conference (10/30/13); ▪ RD attended: Annual Habilitation Therapies Conference (10/30/13); and ▪ RN attended: Neurohabilitation Conference 2013 (5/18/13). However, the continuing education spreadsheet submitted did not identify the number of hours that each PNMT member had completed. **PNMT Meetings** Since the last onsite review, the PNMT conducted 99 meetings for the time period from	

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		10/7/13 to 1/31/14 (i.e., 17 weeks). Attendance by core PNMT and back-up members for the 99 meetings conducted from 10/7/13 to 1/31/14 was: ▪ RN: 87% attendance by core member, 3% for back-up member, 90% overall; ▪ RD: 80% attendance by core member, 8% for back-up member, 88% overall; ▪ PT: 94% attendance by core member; ▪ OT: 76% attendance by core member, 19% back-up member, 95% overall; and ▪ SLP: 82% percent attendance by core member, 9% for back-up member, 91% overall. The attendance percentage, including core PNMT members with back-up members attending when core PNMT members were not present, exceeded 90% overall with the exception of the PNMT RD, which was just slightly under 90%. PNMT meeting minutes (October 2013 to January 2014) included documentation of appropriate topics, including at a minimum: a) referrals; b) PNMT actions; and c) follow-up. The Facility Self-Assessment indicated: "all PNMT meeting minutes documentation still lacks consistently reporting on the status of individuals' clinical health indicators, to assess whether individuals were better or worse, and to analyze the efficacy of their interventions." Based on the Monitoring Team's review, the Monitoring Team agreed with this finding. This is an essential component of the PNMT minutes. **Resolution of Systemic Concerns** As stated in a previous report, the PNMT assessment template had been revised to include the results of environmental monitoring. PNMT members and/or PNMP Coordinators completed the Respiratory Environment Rating Scale form, not dated. The PNMT completed environmental monitoring as part of the initial PNMT assessment. As of February 2013, the PNMT was no longer responsible for the completion of environment assessments on a routine basis. However, this systemic issue had not been resolved, because the Monitoring Team continued to observe unsatisfactory conditions in the Infirmary. For example, dust particles were observed on fan blades and windowsills in a room with an individual with chronic respiratory concerns. The Facility Director and ADOP should work with the PNMT to define the pathways for resolution of systemic issues that are not being addressed with a sense of urgency. At the time of the Monitoring Team's review, the Facility's PNMT had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. Five of the five PNMT members had completed continuing education relevant to physical and nutritional supports that were transferrable to the population served, within the past 12 months. However, the continuing education spreadsheet submitted did not identify the cumulative number of hours that had been completed by each PNMT	

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		member during the past year. However, additional work needed to be completed to achieve substantial compliance with this subsection. In addition to the need for further follow-up on systemic issues previously identified, PNMT meeting minutes should include reports on the status of individuals' clinical health indicators, to assess whether individuals are better or worse, and to analyze the efficacy of their interventions. The Facility remained out of compliance with this provision.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	**Identification of PNM Risk** The Facility HT database continued to produce the following reports that identified individuals who required mealtime assistance, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who were at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"): ▪ Modified Liquids Report; ▪ Adaptive Dining Textures Report; ▪ Individuals Identified as Requiring Mealtime Assistance; ▪ Individuals Using Specific Positioning Equipment/Instructions (this list was for individuals who required positioning assistance associated with swallowing by maintaining elevation of their head. These individuals either had a hospital bed for the elevation, anti-reflux pillow, or supine positioner to maintain the elevation); ▪ Individuals Identified with Diagnosis of Dysphagia; ▪ Individuals At-risk of Receiving a Feeding Tube; and ▪ Integrated Risk Ratings - by Home. The Facility HT Database provided a sustainable system for maintaining and updating these lists. However, the Facility did not have policies and/or procedures that defined the process for maintaining this sustainable system. **Physical and Nutritional Management Team Referral Process** Individuals in Sample O.1 were reviewed to determine if they had been appropriately referred to the PNMT, based on the Facility policy. Two of seven individuals that should have been referred (29%) were. More specifically: ▪ Eight of the 15 individuals (i.e., Individual #315, Individual #134, Individual #58, Individual #128, Individual #191, Individual #19, Individual #194, and Individual #9) did not meet the PNMT referral criteria. ▪ Two of the 15 individuals had been referred to the PNMT (i.e., Individual #130 and Individual #243). ▪ Five of the 15 individuals in Sample O.1 should have been referred to the PNMT (i.e., Individual #327, Individual #3, Individual #252, Individual #17, and Individual #279), but were not. More specifically:	Noncompliance

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		○ Individual #327 had an onset of skin breakdown to her coccyx on 11/18/13. The documentation the Facility presented identified the skin breakdown as Stage II, but there was no date that the breakdown had been healed. The PNMT referral criteria guidelines stated that: "the IDT should refer an individual with any Stage II with delayed healing." ○ Individual #3 was discharged from the hospital on 11/12/13 with a discharge diagnosis of a left hip fracture. The PNMT referral criteria guidelines stated the IDT was to refer an individual with a "fracture of a long bone, spine or hip." Individual #3 had not been referred to and/or reviewed by the PNMT. ○ Individual #252 experienced unplanned weight loss. His weight loss change in six months was listed as a loss of 15.6%. The PNMT referral criteria guidelines stated: "significant/unplanned/verified weight loss of 10% of body weight in 6 months." Individual #242 met this criterion. ○ Individual #17 experienced unplanned weight loss. She had a weight change in six months of a loss of 15.3% of her body weight. Individual #17 also met the PNMT referral guidelines for significant weight loss. ○ Individual #179 had been hospitalized multiple times with a discharge diagnosis of pneumonia (i.e., 9/3/13, 9/30/13, 10/11/13). He should have been referred to the PNMT. Since the last review, one individual had received a feeding tube. ▪ None of one individual (0%) (i.e., Individual #356) who received a feeding tube (not on an emergency basis) since the last review had been referred to the PNMT prior to the placement of the tube. The following was not applicable, because no individual had received an emergency tube placement since the last review: ▪ ___ of ___ (%) individuals who received an emergency feeding tube placement since the Monitoring Team's last review had been referred to the PNMT after the emergency feeding tube placement. **PNMT Assessment** For the four individuals in Sample O.2, four of four PNMT assessments (100%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). Four of four (100%) PNMT assessments were completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances (i.e., critical diagnostics requiring outside appointments, hospitalization, etc., with clearly stated rationale).	

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		Based on review of individuals' records, the comprehensiveness of the PNMT assessment components were as follows: ▪ Four of four (100%) contained date of referral by the IDT; ▪ Four of four (100%) contained the date the assessment was initiated; ▪ Four of four (100%) contained evidence of review and analysis of the individual's medical history; ▪ Four of four (100%) identified the individuals' current risk rating(s), including the current rationale; ▪ Four of four (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data; ▪ Four of four (100%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition; ▪ Four of four (100%) contained assessment of current physical status; ▪ Four of four (100%) contained assessment of musculoskeletal status; ▪ Four of four (100%) contained evaluation of motor skills; ▪ Four of four (100%) contained evaluation of skin integrity; ▪ Four of four (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; ▪ Four of four (100%) contained evaluation of current adaptive equipment; ▪ Four of four (100%) contained nutritional assessment, including, but not limited to history of weight and height, intake, nutritional needs, and mealtime/feeding schedule; ▪ Four of four (100%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ Four of four (100%) identified residual thresholds, if enterally nourished. ▪ Four of four (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. ▪ Four of four (100%) contained respiratory status; ▪ Four of four (100%) contained evidence of review/analysis of lab work; ▪ Four of four (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects; ▪ Four of four (100%) contained discussion as to whether existing supports were effective or appropriate; ▪ Four of four (100%) contained oral hygiene status; ▪ Four of four (100%) contained evidence of observation of the individual's supports at their residence and day/work programs; ▪ Four of four (100%) contained evidence that the PNMT conducted hands-on assessment;	

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		▪ Four of four (100%) identified the potential causes of the individual's physical and nutritional management problems; ▪ Four of four (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individuals' identified problems, including an analysis and rational for the recommendations; ▪ Four of four (100%) contained recommendations for measurable skill acquisition programs, as appropriate; ▪ None of four (0%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; ▪ None of four (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; ▪ Four of four (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); and ▪ Four of four (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT PNMT assessments continued to contain the majority of components necessary. Based on the Monitoring Team's review, compliance for 31 of 33 PNMT assessment elements was 100%. Additional work will be required to establish and/or review individual-specific clinical baseline data to assist teams in recognizing changes in health status and provide a methodology to measure whether or not the supports are effective. In addition, working in conjunction with IDTs, the PNMT will need to develop measurable outcomes related to individual-specific clinical indicators, including but not limited to when nursing staff should contact the PNMT. **<u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u>** For none of the four (0%) individuals, all PNMT recommendations were addressed and/or integrated in the ISPA, Action Plans, and IHCPs. PNMT assessment recommendations were present in PNMT individual-specific meeting minute documentation. However, PNMT recommendations and plans were not integrated into IHCPs. Plans resulting from PNMT recommendations included the following components: ▪ In four of the four (100%) individuals' plans reviewed, the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. ▪ For two of the two (100%) individuals (i.e., Individual #335 and Individual #356) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. HOBE assessments	

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		were not completed for Individual #340 and Individual #333. ▪ In none of the four (0%) individuals' plans reviewed, there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. "Appropriate" is defined as objectives that are relevant to the PNM problem, and "functional" means, when appropriate, objectives that increase an individual's independence. ▪ In none of the four (0%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. ▪ In none of the four (0%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored. ▪ In none of the four (0%) individuals' plans reviewed, the plans defined triggers. ▪ In none of the four (0%) individuals' plans reviewed, the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation: ▪ In none of four (0%) individuals' documentation reviewed, supporting documentation was present to confirm implementation of individuals' action plans within 14 days, or sooner as needed, of the plan's finalization. ▪ In none of the four (0%) individuals' plans reviewed, documentation was provided to show action plan steps had been completed within established timeframes, or IPNs, consultations and/or follow-up reports provided an explanation for any delays, including a plan for completing the action steps. PNMT meeting minutes revealed that the status of recommendations continued to be labeled "pending" from one PNMT meeting to the next. The PNMT continued to struggle with their recommendations not being completed within the established timeframes. The PNMT should be aggressive in ensuring their recommendations are implemented. The PNMT should present these concerns to the Facility Director and ADOP. The Facility Director and ADOP should work with the PNMT to define the pathways for resolution of problems related to individual-specific recommendations, as well as any systemic issues that are interfering with the implementation of PNMT recommendations. **Individuals Discharged by the PNMT** Review of two individuals' PNMT discharge summaries (i.e., Individual #138 and Individual #153) and ISPAs found: ▪ One of the two (50%) (i.e., Individual #153) individuals had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ None of the two (0%) individuals' discharge summary/action plans provided	

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		objective clinical data to justify the discharge. ▪ None of the two (0%) individuals' ISPA meeting documentation provided evidence that any new recommendations, as appropriate, were integrated into the IHCP. ▪ Two of the two (100%) individuals' ISPA documentation and/or action plan included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. In summary, the Facility had a sustainable system to maintain and update lists to identify individuals having physical or nutritional management problems. Some individuals in Sample O.1, who met the PNMT referral criteria and should have been referred to the PNMT, were not. PNMT assessments continued to include many of the assessment elements. To move in the direction of achieving substantial compliance within this section the Monitoring Team recommends the Facility consider the following focus: ensure individuals who meet the PNMT referral criteria are referred to the PNMT with an emphasis on individuals who have experienced respiratory concerns; and ensure PNMT assessments and IHCPs include all necessary components. The Facility remained out of compliance with Section O.2.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	**Identification of Individuals Requiring a PNMP** The Facility reported in the initial document request that 215 of the 236 individuals (91%) living at CCSSLC had a PNMP. Twenty-one of the remaining individuals did not have a PNMP. The Facility had implemented an ISP preparation process that occurred three months prior to the ISP. During this meeting, the IDT conducted planning for the annual ISP meeting. This meeting included the completion of a form that identified IDT members required to attend the annual ISP meeting. For individuals in Sample O.1, ISP attendance and pre-ISP documentation for required attendance were reviewed. The ISP signature sheets were not available for Individual #17 and Individual #252. None of the remaining thirteen individuals (0%) noted the IDT members required to attend the ISP meeting were present as required according the pre-ISP attendance required documentation and/or the individuals' pre-ISP meeting documentation did not provide adequate justification to support non-attendance of therapists and/or a dietician. Some examples of insufficient justification included statements such as: ▪ Assessment is sufficient; ▪ Representative from Habilitation therapies; ▪ Report received; ▪ Information can be obtained from assessment; and ▪ Not receiving direct OT, PT or SLP services (it should be noted the individual did have a PNMP).	Noncompliance

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		In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, residential staff, medical and nursing staff, and the PNMT, as appropriate. Per current State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. The absence of team members (i.e., RD, OT, PT, SLP, Dental, psychologist, medical provider and direct support professional) impacted the team's ability to provide adequate input in a review of the effectiveness of an individual's PNMP and the need for revision of an individual's PNMP, if appropriate. The review of an individual's PNMP should be an important factor when identifying disciplines that should be present during the annual ISP meeting. None of 15 (0%) PNMPs in Sample O.1 were adequately reviewed by the individual's IDT in the annual ISP meeting. Each individual's ISP had a section for the review and approval of the PNMP. The IDT discussion should include evidence of review of effectiveness as well as accuracy, updates/revisions agreed upon by the team, and specified changes required with rationale, but this was not seen in the ISPs reviewed. **PNMP Format and Content** Fifteen PNMPs for individuals in Sample O.1 were reviewed. The review found the following: ▪ PNMPs for 15 of 15 (100%) individuals were current within the last 12 months. ▪ PNMPs for five of 15 (33%) individuals included a list of risk levels and triggers (i.e., Individual #3, Individual #58, Individual #315, Individual #19, and Individual #134). ▪ In two of 15 (13%) PNMPs, there were large and clear photographs with instructions (i.e., Individual #17, and Individual #9). ▪ Thirteen of 15 (87%) PNMPs listed the adaptive equipment required by the individual with rationale (i.e., Individual #130, Individual #3, Individual #58, Individual #315, Individual #9, Individual #327, Individual #128, Individual #19, Individual #243, Individual #194, Individual #252, Individual #179, and Individual #134). Individual #17 and Individual #191's PNMPs listed adaptive equipment, but did not include the rationale. ▪ Nine of the 15 individuals used a wheelchair as their primary mobility (i.e., Individual #130, Individual #3, Individual #58, Individual #327, Individual #128, Individual #194, Individual #252, Individual #179, and Individual #134). In five of nine (56%) PNMPs for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions were provided (i.e., Individual #130, Individual #58, Individual #327, Individual #194, and Individual #179).	

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		▪ In 15 of 15 PNMPs (100%), positioning was adequately described per the individuals' assessments. A review of OT/PT assessments showed the PNMPs did provide a description of alternate positioning, including safe elevation ranges, alternate, bedtime, other positioning as indicated, and as appropriate, non-foundational/individual-specific instructions. ▪ In 15 of 15 (100%) PNMPs, the type of transfer was clearly described, or the individual was described as independent. ▪ In 11 of 15 (73%) PNMPs bathing instructions were provided (i.e., Individual #130, Individual #3, Individual #58, Individual #315, Individual #17, Individual #9, Individual #327, Individual #19, Individual #179, Individual #134, and Individual #191). For the remaining four individuals, staff instructions did not consistently include strategies, independence, and/or level of staff assistance required. ▪ In 14 of 15 (93%) PNMPs toileting-related instructions were provided, including check and change. For Individual #243, instructions were not provided to identify the level of independence, degree of safe elevation, and/or level of staff assistance required during toileting. ▪ In 15 of 15 (100%) PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. ▪ Two individuals did not have dining plans (i.e., Individual #243 and Individual #191). In 13 of 13 (100%) PNMPs/dining plans, instructions related to mealtime were outlined, including for those who received enteral nutrition. ▪ Thirteen of 13 (100%) dining plans were current within the last 12 months. ▪ Eight individuals had feeding tubes with no oral intake (i.e., Individual #130, Individual #58, Individual #9, Individual #327, Individual #194, Individual #252, Individual #179, and Individual #134). None of eight (0%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In five of 13 (38%) PNMPs/dining plans, position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail (i.e., Individual #130, Individual #128, Individual #19, Individual #179, and Individual #134). In the remaining individuals' PNMPs, the photographs were not large enough to guide staff. ▪ Seven individuals ate orally within this sample (i.e., Individual #3, Individual #315, Individual #17, Individual #128, Individual #19, Individual #243, and Individual #191). Two of these seven individuals did not have a dining plan. o In five of five (100%) PNMPs/dining plans, for individuals who ate orally, diet orders for food texture were included. o In five of five (100%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified. o In three of five (60%) (i.e., Individual #3, Individual #315, and	

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		Individual #128) PNMPs/dining plans for individuals who ate orally, dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. The remaining two individuals' dining plans listed adaptive equipment, but no rationale was provided. ▪ In 11 of 15 (73%) PNMPs, medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency (i.e., Individual #130, Individual #3, Individual #58, Individual #9, Individual #327, Individual #243, Individual #194, Individual #252, Individual #179, Individual #134, and Individual #191). ▪ In 13 of 15 (87%) PNMPs, oral hygiene instructions were included, including general positioning and brushing instructions. The remaining two individuals' PNMPs did not include general positioning and/or brushing instructions (i.e., Individual #130, Individual #3, Individual #58, Individual #315, Individual #9, Individual #327, Individual #128, Individual #19, Individual #194, Individual #252, Individual #179, Individual #134, and Individual #191). ▪ Fifteen of 15 (100%) PNMPs included information related to communication (i.e., how individual communicated, and how staff should communicate with individual). **<u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u>** Occupational and Physical Therapies: Informing Staff on Physical Nutritional Management Plans (PNMPs), P.2, revised 6/13/13, outlined the steps to be followed to inform staff of an individual's PNMP revision. A copy of the revised PNMP and a new acknowledgment form was to be placed in the Individual Notebook and another copy was to be placed in the Medex. The Home Team Leader and/or designee were responsible for continuing the revised PNMP pass-down process at each shift change. The Nurse Case Manager or designee also would continue the pass-down process at each shift change. All direct contact staff, including nurses, were responsible to ensure they were aware of the individual's supports as listed on the PNMP as evidenced by their signature on the acknowledgment form attached to the back of the PNMP before assuming responsibility for an individual. Furthermore, the Residential Coordinators and PNMP Coordinators randomly spot-checked the PNMP acknowledgement forms to ensure staff working with the individuals had signed the PNMP acknowledgement form. Staff would be subject to disciplinary action for working with individuals if they had not signed the PNMP acknowledgement form. ▪ For the individuals in Sample 0.1 with PNMPs for whom the IDT identified changes were needed to the PNMP after the annual ISP meeting, 12 of 12 individuals' revised PNMPs (100%) (i.e., Individual #130, Individual #3, Individual #58, Individual #315, Individual #17, Individual #9, Individual #128,	

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		Individual #19, Individual #243, Individual #194, Individual #179, and Individual #134) had been reviewed and revised, and their records contained PNMP acknowledgement forms with staff signatures. ▪ For individuals for whom the PNMP was revised, there was supporting documentation that 12 of the 12 (100%) individuals' revised PNMPs had been implemented as evidenced by the receipt of the revised PNMP by the home, and staff signatures that were in alignment with the PNMP revision date. It was positive that the Facility had a process in place to make staff with direct contact responsibilities, including direct support professionals and nursing staff, aware of changes to PNMPs. However, to achieve substantial compliance with this section, individuals' PNMPs should include the necessary components as discussed in this section. In addition, IDTs need to review and document their decisions about individuals' PNMPs, which should include evidence of review of effectiveness as well as accuracy, updates/revisions agreed upon by the team, and specified changes required with rationale. The Facility remained out of compliance with this provision.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** During the Monitoring Team's onsite review, a member of the Monitoring Team, PNMT OT, Facility therapists, PNMP Coordinators, the Director of Residential Services, and the Unit Director for Ribbonfish completed mealtime and snack observations in Coral Sea and Ribbonfish. These observations occurred in dining rooms during lunch and/or dinner as well as an activity room where snacks were being presented. Twenty-four individuals were observed during a meal and/or a snack (i.e., Individual #45, Individual #283, Individual #278, Individual #181, Individual #366, Individual #307, Individual #207, Individual #93, Individual #146, Individual #128, Individual #222, Individual #244, Individual #10, Individual #304, Individual #3, Individual #367, Individual #19, Individual #376, Individual #315, Individual #228, Individual #159, Individual #291, Individual #367, and Individual #103). Nine of 24 (38%) individuals' staff were following dining plan instructions (i.e., Individual #45, Individual #282, Individual #278, Individual #181, Individual #366, Individual #307, Individual #207, Individual #93, and Individual #146). The following concerns were noted during observations in Ribbonfish: ▪ The mealtime monitor present was completing a mealtime monitoring form, but this did not provide adequate time to provide coaching and mentoring to ensure table captains implemented an individual's dining plan correctly; ▪ The mealtime environment was chaotic and unorganized; ▪ Individuals were having to sit for an extended period of time waiting for food; ▪ Adjustable stools were not available to staff to ensure they were at eye level to assist and/or prompt an individual during the meal; ▪ Table captains left the table and were not available to prompt individuals to slow their eating pace, take a smaller bite, and take a drink;	Noncompliance

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		▪ Individuals were poorly positioned during the meal in wheelchairs and/or regular dining chairs without intervention by the mealtime monitor and/or table captain; ▪ Dining plans were lying on the table, but staff were not referring to the dining plans before presenting food and/or fluid; ▪ Individuals were eating at eight tables, which made it very difficult for the mealtime monitor to intervene and provide coaching and mentoring when table captains were breaching an individual's dining plan. For example, individuals were being assisted at too fast a pace and/or staff were not prompting individuals to slow their pace; staff were presenting too large a bite and/or were not prompting individuals to decrease the bite size, and were not interspersing presentation of food and fluid and/or prompting individuals to take a drink; The following concerns were noted during observations of snack times in Coral Sea: ▪ Snacks were not presented in a timely manner. For example, multiple snacks had not been presented to individuals at 4:10 p.m. on Thursday. ▪ Snacks were being presented without staff referring to the individual's dining plan. Although campus-wide training had been conducted on the provision of snacks, additional work was needed to ensure individuals received snacks within a reasonable time period that did not encroach on their mealtime. In addition, dining plans needed to be readily available for staff reference during presentation of a snack. On a positive note, an observation of dinner on Thursday in the Coral Sea dining room did not reveal mealtime errors. For example, individuals were being brought to eat in different waves so that the dining room was not noisy and chaotic. Table captains did not leave the table during the mealtime. Staff were referring to the dining plans and were following the written instructions. This mealtime observation was similar to the mealtime observation that was completed at Coral Sea during the last review. The Facility should implement a Mealtime Management workgroup and proceed with a sense of urgency to develop strategies to resolve these issues over the next six months. Most importantly, the statewide initiative for the Mealtime Management system should be implemented campus-wide, as appropriate to the needs of the individuals. A member of the Monitoring Team, along with the PNMT OT, Facility therapists, and two PNMP Coordinators completed observations of the implementation of PNMPs. Observations were completed in the Infirmary, the residences of Coral Sea and Ribbonfish, and day programs. These observations confirmed that staff continued to breach PNMPs as noted below:	

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		▪ Two of 17 individuals (12%) (i.e., Individual #65 and Individual #214) were positioned correctly in their seating systems. Individual #308 was not correctly positioned in his wheelchair. The following 15 individuals were poorly positioned in their seating systems: Individual #333, Individual #77, Individual #134, Individual #150, Individual #8, Individual #132, Individual #56, Individual #379, Individual #194, Individual #210, Individual #110, Individual #263, Individual #367, Individual #308, and Individual #184. ▪ None of four (0%) individuals' alternate positioning plans (i.e., Individual #181, Individual #179, Individual #333, and Individual #224,) were implemented as written. ▪ None of seven (0%) individuals' transfer plans (i.e., Individual #150, Individual #19, Individual #67, Individual #287, Individual #110, Individual #136, and Individual #200) were conducted safely. Staff implementation of bathing, and oral hygiene were not observed during this review, so the following were not completed. However, they will be assessed during upcoming reviews, and are necessary to achieve substantial compliance: ▪ ____ of ____ (%) oral hygiene plans were implemented as written; and ▪ ____ of ____ (%) bathing plans were implemented as written. Some of the examples of individuals' PNMPs being breached in the Infirmary included: ▪ A direct support professional had not read and signed an individual's PNMP acknowledgement form. This individual had sustained a fracture, was recovering from surgery, however, his safety mat had not been placed beside his bed; ▪ An individual was being assisted to eat without the direct support professional referring to her dining plan; ▪ Two individuals were not at the prescribed elevation in bed; ▪ An individual did not have the prescribed support in place to maintain his sidelying position in bed; and ▪ Dust accumulation was present on fan blades, window ledges, etc., which was of concern as one of the individuals had chronic respiratory issues. Observations in Coral Sea included: ▪ An individual was lying flat in bed and the chain was not placed at the correct position on the frame of the bed; and ▪ Multiple individuals were not positioned correctly in their wheelchairs. Observations in Ribbonfish with a Facility OT, PT, and two PNMP Coordinators found the following: ▪ Two staff transferred an individual from her wheelchair to a bathing trolley for	

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		check and change. The transfer was poorly performed, because the area was not cleared to ensure safety, the staff did not communicate with each other or the individual, staff were using poor body mechanics, the transfer was performed too quickly, and the individual was not lowered slowly to the bathing trolley. ▪ During the observation of a mechanical lift transfer, the Facility therapists and PNMP Coordinators had to intervene from the beginning to the end of a mechanical lift transfer. Staff did not have the correct sling as prescribed on the PNMP. The correct sling had to be located and placed under the individual. The staff conducting the transfer did not place the correct sling properly, and the PNMP Coordinators had to intervene to fix the placement of the sling. In addition, the two staff were not positioning themselves correctly to ensure safety to the individual's arms and legs as the mechanical lift was being raised. The Facility therapists and PNMP Coordinators had to continually prompt the two staff throughout the mechanical lift transfer and finally had to demonstrate the correct techniques. The Facility therapists and PNMP Coordinators were in agreement with the Monitoring Team that these transfers were poorly performed. These staff should receive training as soon as possible and complete a competency performance check-off to demonstrate their competency in performing transfers. Poor staff performance of transfers place an individual as well as staff at risk for injury. The Facility should complete observations of staff in Ribbonfish completing transfers to assess all staff members' competency in performing transfers. ▪ PNMPs were on shelves and staff were not referring to individuals' PNMPs. As stated during multiple reviews, the correct implementation of PNMPs by staff should be addressed urgently. This should be a <u>major focus</u> over the next six months. To succeed in this endeavor, it will be important to have an interdisciplinary problem-solving approach to analyze why staff are not implementing PNMPs, and then implement strategies to reverse this ongoing practice. To achieve substantial compliance within this section, the Facility should, with a sense of urgency, place a high priority on staff compliance with individuals' PNMPs. The Facility remained out of compliance with this provision.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems	**<u>New Employee Orientation (NEO)</u>** The Facility had developed and implemented a PNM foundational competency-based training curriculum that contained the following components, and it continued to be considered comprehensive: ▪ Lifting and transfers; ▪ Positioning (e.g., alternate, wheelchair, and bathing/showering); ▪ Adaptive equipment;	Noncompliance

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	have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	▪ PNMP orientation and implementation; ▪ Safe mealtime strategies; and ▪ Basics of dysphagia. The Facility reported 164 new employees were hired from August 2014 to January 2014. One hundred and fifty-three of 164 new employees (93%) had successfully completed the 22 PNM competency performance check-offs. The categories/positions of staff that required PNM-related NEO training included direct support professionals, dentists, dental assistants/hygienists, program specialists, rehab therapy technicians, behavioral analysts, behavioral health specialists, licensed nurses, registered nurses, physicians, QIDPs, therapists, therapy assistants, and PNMP Coordinators. **PNM Core Competencies for Current Staff** The Facility Self-Assessment reported 597 of 636 (94%) current staff that required training successfully completed the current PNM core competencies (i.e., foundational skills) and performance check-offs. Thirteen of 13 staff (i.e., PNMP Coordinators) (100%) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. **Annual Refresher Training** As stated above, 597 of 636 (94%) of Facility veteran staff that required training had completed annual refresher competency-based training and performance check-offs within the last 12 months. **Individual Specific Training** The Facility submitted a list of 29 individuals whose PNMPs required individual-specific training, dated 3/28/14. The number of individuals requiring individual-specific training had increased by eight individuals since the last review. The Occupational and Physical Therapies: Informing Staff on Physical Nutritional Management Plans, P.2, described the provision of individual-specific training. When an individual's staff required individual-specific training, a therapist would provide competency-based training to a PNMP Coordinator. The PNMP Coordinator was responsible for demonstrating competency for the specific objective as well as teaching the objective (i.e., three-person transfer, custom right sidelying positioning device, dining presentation techniques, and lower body positioner). When this dual competency was achieved, the PNMP Coordinator was responsible for completing competency-based training with home staff. The policy stated that: "all staff who will work with an individual who	

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		requires individual-specific training must be trained ***prior to*** working with the individual." The staff working with three of the individuals' (i.e., Individual #130, Individual #315, and Individual #134) in Sample O.1 and one of the individuals' in Sample O.2 (i.e., Individual #340) required individual-specific competency-based training. The Facility reported that the list of all staff that had successfully completed individual-specific training and performance check's offs was not in place. Consequently, the following could not be reviewed: ▪ For ___ of ___ staff assigned to individuals with PNMPs, there is evidence of exchange of the information included in the PNMP prior to the provision of services. ▪ ____ of ____ (%) staff assigned had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. There were 23 approved trainers for PNM individual-specific training. This included three occupational therapists, two certified occupational therapy assistants (COTA), four physical therapists, two physical therapy assistants (PTA), six speech language pathologists, two speech assistants, and four PNMT members (i.e., PNMT PT, OT, SLP, and Nurse). The Facility was providing PNM foundational training to new employees and veteran staff during annual refresher training. However, additional work needed to be done to ensure staff providing supports to individuals successfully completed PNM individual-specific training. The Facility remained out of compliance with this provision.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	**<u>Facility's System for Monitoring of Staff Competency with PNMPs</u>** The HT Department continued to use the Compliance Monitoring tool to monitor staff compliance with meals. The Compliance Monitoring form had instructions and identified additional indicators that were to be monitored for meal/snack, medication administration, oral care, positioning, lifting/transfer, bathing, and communication. The Compliance Monitoring Level of Compliance - CCSSLC Audit by Individual HT database report, with a date range from 8/1/13 to 1/31/14, indicated that compliance monitoring had been completed 1222 times during this time period for 236 individuals. The report provided the following information by individual: monitoring date, home, type of monitoring, name of staff completing monitoring, identification of the shift on which the monitoring occurred, and the compliance score. The Monitoring Team's analysis of this report found the following: ▪ 1219 of the 1222 monitoring forms (99%) focused on oral intake (meals and	Noncompliance

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		snacks); ▪ None of the 1222 monitoring forms (0%) focused on bathing; ▪ Three of the 1222 monitoring forms (less than 1%) focused on medication administration; ▪ None of the 1222 monitoring forms (0%) focused on oral care; and ▪ None of the 1222 monitoring forms (0%) focused on positioning. The monitoring report did not indicate during which shift the monitoring occurred. Consequently, the following could not be completed: ▪ ___ of 1222 monitoring forms (%) were completed during first shift; ▪ ___ of 1222 monitoring forms (%) were completed during second shift; and ▪ ___ of 1222 monitoring forms (%) were completed during third shift. In order to address various types of risk, for the first five indicators, approximately 50 to 60 percent of monitoring should occur during meals, including individuals that are enterally nourished, with others evenly distributed; and monitoring should occur across all three shifts, with approximately 15 percent on third shift, and evenly distributed across first and second shifts. As a result, the PNMP monitoring process did not cover all areas that were likely to provoke swallowing and/or times of day. The following concerns were noted from the compliance monitoring database report: ▪ Ten of the 1222 forms (less than 1%) were scored below 80%; ▪ One of the 1222 forms (less than 1%) had a score of 80%; ▪ Fifteen of the 1222 forms (1%) had a compliance score of 88%; ▪ Thirty-six of the 1222 (3%) forms were scored at 89%; ▪ Nine of the 1222 forms (less than 1%) were scored at 90%; and ▪ 1151 of the 1222 forms (94%) were scored at 100%. Given that the Monitoring Team was continuing to find concerns with staff's implementation of PNMPs (as discussed in further detail with regard to Section O.4), the validity of these findings were questionable. In addition, the PNMP compliance monitoring during this time period did not cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, such as bathing, oral care, lifting/transfers and positioning. Due to the absence of monitoring within these areas, issues might exist that had not been identified. Medication administration had been monitored three times during this time period, which was not adequate. **<u>Monitoring for Individuals in Samples</u>** The CCSSLC Occupational and Physical Therapies: Documenting Meal Monitoring, policy P.4, indicated the following: ▪ Nursing was to conduct meal monitoring quarterly; and	

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		▪ HT staff were to monitor individuals at high risk for aspiration, respiratory compromise, and choking at meals twice a month. Individuals at medium risk in these categories were to be monitored once per month. Fifteen individuals in Sample O.1 were rated as being at high and/or medium risk for one or more of the identified PNM risk indicators (i.e., aspiration, choking, falls, fractures, respiratory concerns, and/or skin integrity). None of the fifteen individuals (0%) were monitored at the frequency per the Facility's policy for meals. PNMP monitoring should also have been conducted for positioning, lifting/transfers, medication administration, bathing, and oral care. For none of four (0%) individuals in Sample O.2 did the frequency of PNM compliance monitoring over the past three months occur as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. The following metrics could not be reviewed, because the Compliance Monitoring Level of Compliance - CCSSLC Audit by Individual HT database report did not provide sufficient data: ▪ For the three months prior to the review, ___ of the expected _____ monitoring sessions per policy or the individuals' assessments and/or plans (%) were completed timely. ▪ For the past three months, problems were noted on _____ of the ____ monitoring forms. Of these, documentation of adequate follow-up was provided on the form for ____ (___%). CCSSLC Occupational and Physical Therapies: Documenting Meal Monitoring, P.4, described the steps to complete meal monitoring. However, this policy was not comprehensive. At a minimum, the monitoring policy should include: ▪ Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, oral care, personal care, wheelchair and alternate positioning, transfers, medication administration, etc.); ▪ Training and validation process by therapists (i.e., content experts) for monitors (i.e., PNMP Coordinators, Habilitation Therapy Technicians) to achieve accurate scoring and a high level of inter-rater agreement; ▪ Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) that require individual-specific enhanced PNMP monitoring; ▪ Formal schedule for monitoring to occur; ▪ Requirement that all monitoring forms provide instructions for individual monitoring indicators to support scoring consistency and inter-rater agreement;	

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		▪ Auditing process of completed monitoring forms to ensure compliance with Facility policy; ▪ Development and implementation of a system to track and trend monitoring results to resolve individual-specific and systemic issues; and ▪ Establishment of a threshold for staff re-training for monitoring results that demonstrate repeated staff non-compliance with PNMPs and therapy programs. In summary, the HT Department was monitoring staff's PNMP compliance for meals, but PNMP monitoring needed to be expanded to include bathing, oral care, medication administration, lifting/transfers, and wheelchair/alternate positioning. The Facility remained out of compliance with this provision.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**IDT and PNMT Monitoring to Assess Individuals' Progress and/or Effectiveness of Plans** None of the 15 (0%) individuals' records in Sample O.1, and none of four (0%) individuals in Sample O.2 contained evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM status. None of the 15 (0%) individuals' records in Sample O.1, and none of four (0%) individuals in Sample O.2 contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans were monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans. The outcome of effectiveness monitoring should be to ascertain if prescribed interventions have been effective in minimizing and/or eliminating identified PNM concerns, and in instances in which progress has not been made, interventions should be reviewed and modified, as appropriate. Simply put, is the individual better or worse? This question should be answered through a review and analysis of data that staff are collecting and measuring against goals in the ISP/IHCP. These goals should be based on objective clinical data (e.g., identification of an oxygen saturation threshold that an individual will maintain for an identified period of time). The objective clinical data that should be collected to support the individual's health/wellness should be identified in individual's IHCP goals and tracked by identified staff (e.g., nursing). Therapists should complete effectiveness monitoring by reviewing data in individuals' records and direct observation, which might include a hands-on assessment. For none of the three (0%) individuals (i.e., Individual #130, Individual #243, and Individual #191) receiving direct therapy, the record contained evidence that documentation was reviewed of the plan's effectiveness based on objective clinical data included in the plan.	Noncompliance

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		Because plans did not include clinical indicators to alert teams to changes in status for the individuals in Sample O.1, the following could not be evaluated, but will be during upcoming reviews: ▪ _____ of the _____ individuals' records showed a change of status based on the established clinical indicators. Of these, ___ (__%) contained evidence that, as appropriate, the team met and interventions were reviewed and changed, as appropriate, in a timely manner. Trigger sheets and supporting documentation was reviewed for individuals in Sample O.1: ▪ None of 15 (0%) individuals' records included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. ▪ None of 15 (0%) individuals' Trigger sheets included individualized triggers as indicated. ▪ None of 15 (0%) individuals' Trigger sheets were completed correctly. ▪ None of 15 (0%) individuals' Trigger sheets were reviewed by the RN on a daily basis. In summary, the Facility had not implemented an effectiveness monitoring system that included tracking of individualized clinical indicators and triggers to evaluate and report on the individuals' progress, and revise interventions, as appropriate. The Facility remained out of compliance with this provision.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Assessment of Individuals Who Receive Enteral Nourishment** The Facility maintained a list of individuals who received enteral nourishment. The Facility had a sustainable system to maintain and update the list of individuals who received enteral nutrition. However, a Facility policy and/or procedure had not memorialized this sustainable system. A review was conducted of the seven individuals in Sample O.3 (i.e., Individual #130, Individual #58, Individual #9, Individual #327, Individual #194, Individual #179, and Individual #134) who received enteral nutrition. Four of seven (57%) were evaluated at a minimum annually (i.e., Individual #327, Individual #134, Individual #179, and Individual #130). None of the seven (0%) individuals reviewed had an appropriate evaluation to determine the medical necessity of the tube. The information necessary for such an assessment was supposed to be summarized on the IRRF, and the team discussion/deliberations regarding the necessity of the tube documented on the IRRF. Although the IRRF now contained space for this, the necessary information and/or team	Noncompliance

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		deliberations were not documented for the individuals in the sample. In order to determine medical necessity of enteral nutrition, documentation should include the following areas: ▪ Nutritional assessment of current type of formula and schedule; ▪ Identification of primary medical diagnoses that contributes to the need for non-oral means of nutrition; and ▪ Assessment of Oral Motor status by SLP and/or OT to provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate. The three individuals (i.e., Individual #35, Individual #45, and Individual #78) admitted since the Monitoring Team's last review ate orally and did not receive enteral nourishment. The following was not applicable for review: ▪ ____ of the ____ (%) individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** None of the seven (0%) individuals in Sample 0.3 who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. All individuals receiving enteral nutrition should be assessed annually by the IDT to determine if improvements can be made to progress towards a less restrictive diet. This means the individual should be: ▪ Assessed by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual is a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as part of assessment findings. ▪ Assessed by the Nutritionist/Dietitian regarding current formula and schedule of feedings to determine if there is a possibility for modification to the least restrictive schedule. Justification for/or against modification of formula/schedule should be included as part of assessment findings. There were no individuals who as the time of the review and/or since the last review had a plan developed and implemented for a potential return to oral intake. As a result, the following metrics were not evaluated, but will be, as applicable, during upcoming reviews: ▪ ____ of the ____(%) individuals who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process. The plan	

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		should include all of the following components: o Staff training required prior to implementation; o Staff roles and responsibilities (e.g., implementation and monitoring); o Time and schedule of interventions; o Specific triggers for when the plan should be stopped; o Milestones for progressing with the plan; o Documentation requirements (i.e., method for tracking progress); and o Frequency of subsequent assessments and staff responsible ▪ ____ of the ____ (%) individuals' plans to return to oral eating were based on the results of the IDTs' discussion and integrated in the IHCP, ISP, and/or an ISPA. The IRRF should provide clinical assessment data to identify an individual's potential to return to oral eating and provide justification for the medical necessity of the feeding tube. Any plan the IDT develops should be memorialized in an IHCP that is part of the ISP, and/or documented in an ISPA. ▪ ____ of the ____ (%) individuals' plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. The IHCPs should include timeframes consistent with the clinical needs of the individual. The IHCPs should be implemented according to the timeframes included, unless a reasonable explanation is provided. ▪ ____ (%) of the staff responsible for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. Training conducted by the licensed clinician should include a return demonstration. ▪ ____ of the ____ (%) individuals' plans were monitored as outlined in the plan. Individuals' plans should be monitored to meet the frequency and requirements in the plan, and should be conducted by monitors with demonstrated competency in the plan. ▪ ____ of the ____ (%) individuals' plans were modified by the IDT. For ___ (___%) of these individuals' plans, the IDT met, reviewed and changed interventions, as appropriate, in a timely manner. Individuals' plans should be reviewed by the IDT to determine if the plan is being implemented as written, staff are adequately trained, etc. In addition, if the team determines interventions are not effective, the IDT should revise these interventions. Plans should be revised within 24 hours or sooner if it is a critical concern, when a change is indicated such as for a change in status or based on effectiveness monitoring findings. In summary, the Facility maintained and updated a list of individuals who received enteral nutrition. However, this process was not memorialized in Facility policy and/or procedure. Some of the individuals in the sample who received enteral nutrition were reviewed by the IDT, but the annual assessment did not include necessary components. Individuals who were transitioning to oral eating did not have a formal oral intake plan	

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		that included the necessary components. The Facility remained out of compliance with this provision.	

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section P; o For the following nine individuals in Sample P.1 [i.e., individuals identified with PNM concerns, and/or who had experienced a change of status as evidenced by admission to the emergency room, and/or hospital, and/or received direct therapy intervention(s)]: (i.e., Individual #3, Individual #134, Individual #315, Individual #17, Individual #9, Individual #327, Individual #252, Individual #179, and Individual #128), the following documents: Occupational Therapy/Physical Therapy comprehensive assessment, assessment of status, update in individual record, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition assessment, Speech Language Pathology comprehensive assessment, assessment of status, update in individual record, Head of Bed Elevation assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/Integrated Health Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/RD consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan, dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM issues, and incident reports and Facility investigations for choking incidents; o For the following three individuals in Sample P.2 (i.e., Individual #130, Individual #243, and Individual #191) who were reported to receive direct OT and/or PT services, the following documents: monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o OT/PT assessments for the following three individuals who had been newly admitted: (i.e., Individual #35, Individual #45, and Individual #78); o Facility policies and procedures related to the provision of OT/PT supports and services; o Organizational chart of Habilitation Therapy Department; o Current OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) staff, corresponding caseloads, and CVs for new hires; o Continuing education completed by OTs and PTs, since the Monitoring Team's last onsite visit; o List of individuals who use a wheelchair as primary mobility;

	○ List of individuals with transport wheelchairs; ○ List of individuals with other ambulation assistive devices; ○ List of individuals with orthotics and/or braces; ○ Physical Nutritional Management Maintenance Log; ○ OT/PT Assessments and Updates (templates) with changes made since the Monitoring Team's last review; ○ Tracking Log of completed individual assessments; ○ Wheelchair seating and PNM clinic assessment (templates); ○ Compliance Monitoring form template; ○ Competency-based performance check-off sheet templates for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; ○ Summary reports and monitoring results related to OT/PT; and ○ List of individuals receiving direct OT and/or PT services and focus of intervention. ▪ **Interview with**: ○ Paul Osbourne, Lead PT and Section P Lead; and ○ Steve Strader, PT. ▪ **Observations of**: ○ Individuals in residences, dining rooms, and day programs.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 3/14/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. Based on a review of the Facility Self-Assessment, audit tools, HT database reports and interviews with the Section Lead for P, a Facility PT, and a PCM, the following was found: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: the Settlement Agreement Section P Monitoring Tool, and Facility-developed audit tools. The Section Lead for Section P and the assigned PCM for Section P reported that this tool was in the process of being revised. ▪ The data presented in the Self-Assessment indicated that multiple audits were conducted using the OT/PT assessment audit tool, review of new admissions for timeliness of the completion of OT/PT assessments, audit of ISPs for incorporation of OT/PT recommendations, analysis of PNM foundational training databases for NEO and annual refresher training for PNM foundational training, etc. The data provided evidence that the Facility had assessed its compliance status with Section P. ▪ The Self-Assessment identified the sample sizes used to complete audits. For example, the number of completed audits of assessments (n) was identified in comparison with the total number of assessments produced over the previous six months (N). ▪ The Settlement Agreement Monitoring Tool for Section P had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ▪ The following staff/positions were responsible for completing the Settlement Agreement Monitoring audit tool: the Director of HT, therapists, and the PCM.

	▪ Adequate inter-rater reliability had been established between the Director of HT, therapy staff, and the PCM. The Director of HT and the Facility Program Compliance Monitor (PCM) continued to achieve a high level (i.e., exceeding 85%) of inter-rater agreement. ▪ The Facility used other relevant data sources, including, for example, information from the HT Department databases and/or spreadsheets. ▪ The Facility presented some data in a meaningful/useful way, but in other instances more work was needed. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with Section P.2, and P.3. Sections P.1 and P.4 were rated as not being in compliance. The Monitoring Team did not agree with the Facility's compliance findings for Section P.2, and P.3 for the following reasons: o Section P.2 - Individuals receiving direct therapy did not have adequate plans and monthly progress notes were not completed. o Section P.3 - Substantial compliance with Section O.5 is the standard for compliance in this section. The Facility was not in substantial compliance with Section O.5. Additional information is provided with regard to Section O.5. The Monitoring Team did agree with the Facility's findings of noncompliance for with Sections P.1 and P.4. However, the Facility did have a foundation developed for a sustainable system to monitor in multiple ways individuals' prescribed adaptive/assistive equipment. This monitoring system is described in further detail with regard to Section P.4. ▪ The Facility's data identified areas in need of improvement. For these areas of need, the Facility Self-Assessment provided an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: Three individuals who were recently admitted to the Facility had Occupational Therapy/Physical Therapy (OT/PT) assessments completed within 30 days of admission. Some individuals' OT/PT assessments were not completed at least 10 days prior to the annual ISP and were missing important assessment elements. Individuals in the Monitoring Team's sample who had experienced a change in status did not have assessment updates and/or consultations completed. Individuals receiving direct OT and/or PT interventions did not have plans implemented within 30 days of the plans creation and comprehensive monthly progress notes had not been completed. OT/PT assessment recommendations and/or recommendations for SAPs had not been integrated into individuals' ISPs. Competency-based training for the implementation of PNMPs is addressed in detail with regard to Section O.5. Substantial compliance with Section O.5 is the standard for compliance with Section P.3. The Facility was not in substantial compliance with Section O.5 and therefore Section P.3 was not in compliance. The Facility had developed the foundation of a sustainable system to monitor the condition, availability,

	and effectiveness of individual's prescribed equipment. As discussed with regard to Section O.6, the Facility did not have an adequate monitoring system for PNMPs, because the primary focus was meal monitoring.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	**Definition of Samples** ▪ **Sample P.1** consisted of the following nine individuals: Individual #3, Individual #134, Individual #315, Individual #17, Individual #9, Individual #327, Individual #252, Individual #179, and Individual #128; and ▪ **Sample P.2** consisted of three of the three individuals who received direct OT and/or PT services, including: Individual #130, Individual #243, and Individual #191. **Timeliness of Assessments** Three of three (100%) newly admitted individuals (i.e., Individual #35, Individual #45, and Individual #78) received an OT/PT assessment within 30 days of admission or readmission. Based on review of nine assessments for individuals in Sample P.1: ▪ Six of nine individuals' OT/PT comprehensive assessments or assessments of current status (67%) (i.e., Individual #134, Individual #315, Individual #9, Individual #327, Individual #179, and Individual #128) were dated as having been completed at least 10 days prior to the annual ISP. ▪ Nine of nine (100%) individuals had received an assessment that was current within 12 months for individuals who were provided PNM supports and services. **OT/PT Assessment** Based on review of nine assessments for individuals in Sample P.1 (i.e., Individual #3, Individual #134, Individual #315, Individual #17, Individual #9, Individual #327, Individual #252, Individual #179, and Individual #128), the comprehensiveness of the OT/PT assessments was as follows: ▪ Nine of nine (100%) individuals' OT/PT assessments were signed and dated by both the OT and PT clinicians upon completion of the written report. ▪ Nine of nine (100%) assessments included medical diagnoses. ▪ Nine of nine (100%) assessments included medical history. ▪ Nine of nine assessments (100%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. ▪ Nine of nine (100%) assessments addressed health status over the last year. ▪ Nine of nine assessments (100%) included a comparative analysis that clearly	Noncompliance

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		analyzed the individuals' level of health status with previous years or assessments. ▪ Nine of nine assessments (100%) included a section that reported health risk levels that were associated with PNM supports. ▪ Eight of nine (89%) (i.e., Individual #3, Individual #134, Individual #17, Individual #9, Individual #327, Individual #252, Individual #179, and Individual #128) assessments listed medications and potential side effects relevant to functional status. ▪ Nine of nine (100%) individuals' OT/PT assessments included individual preferences, strengths, and needs. ▪ Nine of nine (100%) assessments included evidence of observations by OTs and PTs in the individuals' natural environments (i.e., day program, home, work). ▪ Nine of nine (100%) individuals' OT/PT assessments included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. ▪ The individuals in the sample used wheelchairs as their primary mobility. Nine of nine assessments (100%) provided a description of the current seating system with a rationale for each component and need for changes to the system outlined as indicated, also with sufficient rationale. ▪ Nine of nine assessments (100%) included discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings. ▪ Nine of nine assessments (100%) included recommendations for services and supports. ▪ Seven of nine (78%) (i.e., Individual #3, Individual #134, Individual #315, Individual #17, Individual #9, Individual #179, and Individual #327) assessments included a comparative analysis of current functional motor and activities of daily living skills with previous assessments. ▪ Nine of nine assessments (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP/dining plan that addressed the individuals' PNM risk levels; ▪ Six of nine (67%) assessments (i.e., Individual #315, Individual #17, Individual # 9, Individual #252, Individual #179 and Individual #128) included discussion of the individual's potential to develop new functional skills. ▪ Nine of nine (100%) assessments identified the need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. ▪ Nine of nine (100%) assessments included a monitoring schedule. The assessments indicated that direct support professionals were to monitor individuals' assistive equipment on a daily basis. PNMP Coordinators were also	

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		responsible for reviewing the status of individuals' equipment. In addition, per policy individuals with high PNM risks were to be monitored monthly and individuals with medium risks were to be monitored quarterly. ▪ Nine of nine (100%) assessments included a reassessment schedule. ▪ Nine of nine (100%) individuals' OT/PT assessments made a determination about the appropriateness of transition to a more integrated setting. As required by State Office, therapists had included their opinion about whether or not the individual could effectively be supported in the community. If the therapist believed the individual could not be supported in the community, the therapist identified what supports the individual needed were missing in the community. ▪ Nine of nine (100%) assessments recommended ways in which strategies, interventions, and programs should be utilized throughout the day. The following elements were not present in some of the assessments: ▪ Medications' potential side effects relevant to functional status; ▪ Comparative analysis of current functional motor and/or activities of daily living skills with previous assessments; and ▪ Discussion of the individual's potential to develop new functional skills. The following individuals in the samples had experienced a change in status since the last review: Individual #130 (i.e., hospitalization and Infirmary admission with diagnosis of pneumonia), Individual #3 (hospitalization with a diagnosis of a left hip fracture), Individual #17 (unplanned weight loss with a loss of 15.3% of her body weight in six months), Individual #9 (hospitalization with a diagnosis of pneumonia), Individual #327 (Stage II skin breakdown identified on 11/18/13 with no date of resolution), Individual #252 (unplanned weight loss of 15.6% of his body weight in six months), Individual #179 (multiple hospitalizations with discharge diagnosis of pneumonia), and Individual #128 (choking incident): ▪ For none of eight (0%) individuals, did updates provide the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data. In summary, the three individuals who were recently admitted to the Facility had OT/PT assessments completed within 30 days of admission. Some individuals' OT/PT assessments were not completed at least 10 days prior to the annual ISP and were missing important assessment elements. Individuals who had experienced a change in status did not have assessment updates and/or consultations completed. The Facility remained out of compliance with this subsection.	

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P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**Direct OT/PT Interventions** Three individuals received direct OT and/or PT services. Sample P.2 was comprised of these three individuals (i.e., Individual #130, Individual #243, and Individual #191). The Monitoring Team reviewed the requested direct therapy documentation and found the following: ▪ One of three (33%) (i.e., Individual #191) individuals' direct intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For two of three (67%) (i.e., Individual #130 and Individual $243) individuals' records reviewed, the current OT/PT assessment and/or consultation identified the need for direct intervention with rationale. ▪ For none of three (0%) individuals' records reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. ▪ For one of one individual's records whose therapies had been terminated (100%) (i.e., Individual #191), termination of the intervention was well justified and clearly documented in a timely manner. Individual #130 and Individual #243's direct therapy had not been discontinued. **Indirect OT/PT Programs** The implementation of these plans is discussed with regard to Section O.4 for PNMPs, and in Section S for skill acquisition plans. **Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** A review of the sample of nine assessments and ISPs/ISPAs for individuals in Sample P.1 (i.e., Individual #3, Individual #134, Individual #315, Individual #17, Individual #9, Individual #327, Individual #252, Individual #179, and Individual #128) and the three individuals in Sample P.2 (i.e., Individual #130, Individual #243, and Individual #191) found the following: ▪ For eight of 12 individuals' ISPs (67%) (i.e., Individual #130, Individual #3, Individual #315, Individual #9, Individual #179, Individual #128, Individual #130, and Individual #191), an OT or PT attended the ISP or ISPA meeting, if the individual was receiving any direct or indirect OT/PT service, or adequate justification was provided. ▪ For individuals receiving OT/PT supports and services, nine of 12 plans (75%) (i.e., Individual #3, Individual #134, Individual #315, Individual #17, Individual #9, Individual #327, Individual #252, Individual #179, and Individual #128) were developed within 30 days of the date of the ISP, or an ISPA meeting following the assessment/update, or sooner as indicated by need. ▪ For none of 12 individuals, (0%), the ISP, or an ISPA following the assessment/update, addressed recommendations outlined in the current	Noncompliance

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		OT/PT assessment. ▪ In none of 12 (0%) ISPs or ISPAs reviewed, skill acquisition programs that had been recommended in the OT/PT assessment were present. ▪ For none of 12 individuals (0%), the ISP/ISPAs contained measurable objectives related to interventions. Generally accepted practice standards for comprehensive progress notes related to PT/OT interventions include that they: ▪ Contain information regarding whether the individual showed progress with the stated goal, including summary of clinical data and other documentation to substantiate progress and/or lack of progress with the therapy goal(s); ▪ Describe the benefit of the goal to the individual; ▪ Report the consistency of implementation; ▪ Identify recommendations/revisions to the OT/PT intervention plan, as indicated, related to the individual's progress or lack of progress; and ▪ Are completed on at least a monthly basis. Based on the Monitoring Team's review: ▪ None of three (0%) individuals receiving direct OT/PT services was provided with comprehensive progress notes at least monthly that contained each of the indicators listed above. The method of review described in Individual #222's direct therapy plan was that the therapist would complete monthly progress notes and the QIDP would complete a monthly review. Daily Progress Notes were submitted, but there were no monthly progress notes provided, including a summary and analysis of the data for the month. ▪ For individuals who received indirect OT and/or PT programs (e.g., PNMPs or SAPs), monthly documentation from the OT and PT and/or QIDP was present for none of the 10 individuals (0%), including the following: o Information regarding whether the individual showed progress with the stated goal(s), including a summary of clinical data to substantiate progress and/or lack of progress with the therapy goal(s); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. In summary, individuals receiving direct OT and/or PT interventions did not have plans implemented within 30 days of the plans creation, and comprehensive monthly progress notes had not been completed. OT/PT assessment recommendations and/or recommendations for SAPs had not been integrated into individuals' ISPs.	

#	Provision	Assessment of Status	Compliance
		Documentation showing review of programs was not found for individuals provided indirect services. The Facility remained out of compliance with this subsection.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	**Competency-Based Training** Competency-based training for direct support professionals related to implementation of PNMPs is addressed in detail with regard to Section O.5. Substantial compliance with Section O.5 is the standard for compliance with this section. The Facility was not in compliance with Section O.5.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**Monitoring System** The Facility did not implement a system for the adequate monitoring of PNMPs. The Facility's monitoring of PNMPs primarily focused on mealtimes, which was not adequate PNMP monitoring. The status of PNMP monitoring is addressed with regard to Section O.6. The Facility submitted the following policies for Occupational and Physical Therapy: ▪ CCSSLC Occupational/Physical Therapy Services, Policy 014, implementation date 10/7/09; ▪ CCSSLC Occupational and Physical Therapies, P.2, revised 6/6/13, and implemented 6/13/13; ▪ CCSSLC Occupational and Physical Therapies: Informing Staff on Physical Nutritional Management Plans, revised 6/6/13, and implemented 6/13/13; ▪ CCSSLC Occupational and Physical Therapies: Maintaining Adaptive – Assistive Equipment, P.3, revised 11/12/12, and implemented 12/3/12; ▪ CCSSLC Occupational and Physical Therapies: Adaptive/Assistive Equipment Supply Lists, P.3.1, revised 5/6/13; ▪ CCSSLC Occupational and Physical Therapies: PNMP Clinic Minutes Instruction, P.3.2, drafted 3/26/13; ▪ CCSSLC Occupational and Physical Therapies: Ensuring Safe Practices During Meals, P.5, revised 4/23/12; ▪ CCSSLC Occupational and Physical Therapies: Ordering and Repairing Beds, P.6, implemented 10/1/12; ▪ CCSSLC Occupational and Physical Therapies: Repairing Beds Protocol, P.6.1, implemented 3/7/13; and ▪ CCSSLC Occupational and Physical Therapies: Competency of Staff Implementing Indirect Services Programs, P.7, draft 3/27/13.	Noncompliance

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		The Facility did have a comprehensive set of OT/PT policies and procedures which included the following elements: ▪ Description of the role and responsibilities of OT/PT; ▪ Referral process and entrance criteria; ▪ Discharge criteria; ▪ Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; ▪ Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; ▪ Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; ▪ Identification of monitors and their roles and responsibilities; ▪ Definition of a formal schedule for monitoring to occur; ▪ Process for re-evaluation of monitors on an annual basis by therapists and/or assistants; ▪ Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; ▪ Identification of the frequency of assessments; ▪ Definition of how individuals' OT/PT needs will be identified and reviewed; and ▪ Requirements for documentation for individuals receiving direct services. HT staff prescribed and provided all necessary adaptive equipment to an individual's home. PNMP Coordinators and/or therapists monitored individuals' prescribed adaptive/assistive equipment using the following forms: ▪ Monthly Person-Specific PNMP Check Sheet, revised 3/27/13; ▪ Monthly Home Equipment Check Sheet; ▪ PNMP Clinic Minutes; and ▪ PNMP data sheets. The PNMP Coordinators were responsible for completing the Monthly Person-Specific PNMP Check Sheet on a monthly basis. The PNMP Coordinator was supposed to notify the prescribing therapist and Home Team Leader of any identified problems. Therapists had five working days to review the form and ensure problems were corrected. If the issues could not be resolved within five working days, a plan and/or course of action to correct the problem was to be developed, including an estimated completion date. In addition, the Facility policy required the PNMP Coordinator Supervisor to accompany the PNMP Coordinator once per month to provide oversight of the adaptive equipment monitoring process.	

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		The Monitoring Team requested three months of monitoring data for adaptive equipment (i.e., December 2013, and January to February 2014). Based on a review of Monthly Person-Specific PNMP Check Sheets for individuals in Sample P.1, for seven of nine individuals (78%) (i.e., Individual #3, Individual #134, Individual #315, Individual #17, Individual #9, Individual #327, and Individual #179), positioning devices and mealtime adaptive equipment identified in the PNMP were monitored for cleanliness and proper working condition for the three months requested. If a problem was identified during the monitoring, it was referred to a Residential Supervisor and primary therapist for resolution. The CCSSLC Occupational and Physical Therapies: Maintaining Adaptive –Assistive Equipment, P.3, identified the steps to be completed for resolution of the identified problem. None of the individuals in Sample P.1 had adaptive equipment that was noted to be in disrepair and/or needed replacement. In summary, the Facility had developed the foundation of a sustainable system to monitor the condition, availability, and effectiveness of individuals' prescribed equipment. The effectiveness of individuals' prescribed equipment was being monitored on an annual basis in PNMP clinics. As discussed with regard to Section O.6, the Facility did not have an adequate monitoring system for PNMPs, because the primary focus was meal monitoring. The Facility remained out of compliance with this section.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of dental care, including for updated policies/procedures/protocols, highlighted areas of approved change; o List of staff in the Dental Department, including names, title/role, and degrees; o List of staff in the Dental Department and their CPR certification status; o For the past six months, minutes from the statewide Dental Committee; o Lists of individuals who within the past six months: ▪ For newly admitted individuals, were seen for dental services, including date of admission, and date of initial evaluation; ▪ Have refused dental services; ▪ Have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed make-up appointment; ▪ Have had a tooth/teeth extraction, including name, date of extraction, and number of teeth extracted; ▪ Have been seen for dental emergencies (e.g., abscess tooth, complications, etc.), including name, date of emergency visit and reason, whether individual complained of pain (yes or no), dentist documentation confirming pain (yes or no), and treatment documented; ▪ Have had preventative dental care; ▪ Have had restorative dental care including name, date of completed restorative work, and for each appointment completed, type of restorative work; and ▪ Were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams, including name, and date of completed annual exam; o Most recent comprehensive exams and other dental visits in prior six months for one individual from each residence. Copy from dental office's record of visit and copy form active record of same visit, including source of documentation (i.e., IPN or dental section of active record/dental office record) for: Individual #161, Individual #174, Individual #282, Individual #93, Individual #198, Individual #321, Individual #308, Individual #16, Individual #46, Individual #118, Individual #155, Individual #236, and Individual #283; o For five most recent off-site oral surgery consults and progress notes past six months for following individuals: Individual #325, Individual #275, Individual #90, Individual #354, and Individual #33; o List of abbreviations used in all dental records/reports; o For the past six months, any data summaries used by the Facility related to dental services, and/or quality assurance/enhancement reports, including subsequent corrective action plans;

	○ Attendance tracking sheet for dental appointments for the past six months; ○ List of refusals for the past six months per date of refusal, including reason for appointment (i.e., prophylaxis, annual, etc.), name, dates of refusals and date of completion; ○ List of those who have not seen dentist in one year and reason; ○ List of those who have outstanding need for dental x-rays, according to current professional standards, and type of x-ray that is needed to fulfill requirement/recommendations, including date of last full mouth x-rays; ○ List of those who were edentulous at time of the last on-site visit, and those who have become edentulous since that time; ○ List of reasons for missed appointments other than refusals per date for past six months (including reason for appointment, i.e., prophylaxis, annual, etc.); ○ Dental training documentation (i.e., dates, signature rosters, content) for past six months for new employee orientation, chair-side in dental clinic, in the residence for individuals and staff, and any annual refresher training course for direct support professionals; ○ List of interventions per individual for missed appointments (i.e., follow-up appointment scheduled, whether follow-up completed, any correspondence to QDDP, residential manager, team, etc.); ○ QDDP, IDT minutes that review, assess, develop, and implement strategies for dental visit refusals and no shows last six months, including any ISPA that documented discussion/action plans concerning dental refusals and other dental missed appointments; ○ For five most recent emergency exams, IPN from start of emergency to closure, and copy of Dental Department evaluation and treatment including time and date of first symptom/concern, and time/date first seen in the dental office for: Individual #313, Individual #229, Individual #327, Individual #59, and Individual #253; ○ Appointment schedule for those undergoing general anesthesia/conscious sedation, including individuals for whom general anesthesia was scheduled but the appointment was not completed, and the reason; ○ For five individuals undergoing general anesthesia/conscious sedation, complete copy of dental record from start of concern to closure, including copy of any operative reports, copy of any monitoring tapes, consents, second opinions, consult reports, pre-operative checklist or evaluation (i.e., medical, anesthesia clearance, etc.,), and post-operative checklist or monitoring forms, and IPN on date of procedure, etc., for: Individual #38, Individual #313, Individual #276, Individual #181, and Individual #136; ○ For the past two months, copies of any correspondence concerning restraint and sedation use at time of office visit (i.e., to QDDP, team, psychologist, etc.); ○ In response to request for information concerning individuals given dental pre-treatment sedation, copies of progress notes/vital sign logs, other pre-appointment assessments from active record and dental office from start of sedation in residence (if applicable) to release from monitoring (including pre-treatment sedation sheets). Information was provided for the following five individuals: Individual #126, Individual #260, Individual #154, Individual #57, and Individual #207;

	○ Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as PO sedation, IV or general anesthesia; ○ Copy of any restraint and sedation tracking list/system used by the Dental Department (i.e., type of restraint, reason, sedation plan, drug used and dosage, effectiveness of restraint, trial of less restrictive approach (lower dosage, less mechanical restraint duration, etc.)); ○ In past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; ○ In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; ○ In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; ○ For most recent five extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure, for: Individual #38, Individual #137, Individual #13, Individual #198, and Individual #338; ○ List of those who receive suction tooth-brushing treatment; ○ List of those who have been identified as benefiting from suction tooth-brushing treatment but who are not receiving suction tooth-brushing at time of the Monitoring Team's visit (i.e., waiting for equipment, training, care plan revision, etc.); ○ Dates of dental record annual examinations/assessments and treatment plan record completed in last six months, and the date of previous dental record annual examination/assessment and treatment plan record for all individuals, including copies of these annual exams (including odontogram); ○ Copy of five most recent annual dental summaries provided for the ISP submitted for the following individuals: Individual #53, Individual #7, Individual #144, Individual #154, and Individual #223; ○ The most recent/current Facility oral hygiene data for all individuals in past year, including numbers and percentages of good, fair, and poor ratings, with date of data; also, a list of individuals for whom an oral hygiene rating was not obtained during this time; ○ For those individuals for whom care plans/ISP indicate they brush their own teeth, the oral hygiene scores, with dates of the scores, over the prior one year; ○ List of those individuals that floss their own teeth; ○ List of individuals provided instructions on flossing with dates of training; ○ For those individuals that brush their own teeth but do not floss, the reason for not flossing their own teeth. Requested submitted information included whether a skill acquisition plan had been created or implemented for flossing; ○ For those that are edentulous, list of those with dentures; ○ For those edentulous without dentures, list of reasons with documentation as indicated; ○ List of those who have been identified as benefiting from suction tooth brushing treatment but who are not receiving suction tooth brushing; ○ Summary information on desensitization plans since Monitoring Team's last visit, including any evidence of implementation of plan, progress logs, etc.;

	○ For those undergoing Total Intravenous Anesthesia (TIVA), any incident of injury in 24 hours following TIVA administration in prior six months; ○ For those with documented pneumonia, for each individual, date pneumonia documented, date of the most recent dental visit prior to the pneumonia, type of procedure/visit completed, and type of anesthesia (i.e., TIVA, oral, local, none, etc.) in past six months; ○ For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; ○ For the self-assessment process, a list of the databases utilized (other than audit information), including title of each database/chart/table with date range of each database, and for data collected periodically rather than continuously, the frequency of data collection; and ○ Presentation Book for Section Q. ▪ **Interviews with**: ○ Enrique Venegas, DDS, Dental Director; and ○ Kathy Roach, RDH.
	Facility Self-Assessment: For Section Q, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: Section Q Dental Services Settlement Agreement cross-referenced with Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) Standards. ○ These monitoring/audit tools included some indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify any additional indicators that are relevant to making compliance determinations. ○ The monitoring tools included adequate methodologies, such as record reviews, and review of numerous databases. ○ The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. ○ The following staff/positions were responsible for completing the audit tools: Dental Hygienist. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be complete and accurate. Numerous databases were maintained, and they are listed with regard to Section Q.2. These databases were readily available and had consistent accuracy.

	The Dental Department continued to expand data available into other clinical areas of dental services, such as the number of new caries since the individual's last visit, the degree of periodontitis, the number of extractions per month/quarter, etc. These are important outcome measurements. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Provided clear concise findings of the audits, as well as summarization of database findings; o Presented findings consistently based on specific, measurable indicators; and o Consistently measured the quality as well as presence of items. ▪ The Facility rated itself as being in compliance with the Section Q.1. This was consistent with the Monitoring Team's findings. ▪ The Facility's data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying, for example, a need to focus on refusals (which had increased over time), as well as desensitization plan development and implementation.
	Summary of Monitor's Assessment: The Dental Department had been able to maintain a low percentage of individuals with poor oral hygiene. The annual summaries were complete and provided valuable information to the IDTs and to the community for those that were transitioning. Annual summaries were available for incorporation into the ISP process in a timely manner. There remained a low rate of edentulous individuals. There was also a low rate of need for oral sedation and intravenous (IV) sedation. There were numerous databases that were of high quality and appeared complete. The Dental Department had created new clinical indicators, focusing on the impact/outcome on the individual, such as the amount of new tooth decay, the degree of periodontitis, etc. This had the potential to provide a measure of whether the Dental Department was accomplishing its goals for the various services provided. Challenges did remain, but were focused on a few areas. There were a few desensitization plans in place with evidence of data collection showing progress might be occurring. However, these plans had only been finalized and implemented for a small number of the population eligible for such plans. The Dental Department also determined the need to reduce the number of refused appointments. This will require interdepartmental cooperation to achieve. The Monitoring Team determined the Dental Department was in substantial compliance with Section Q.1.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall	<u>Staffing</u> The Dental Department was staffed by two dentists, one certified dental assistant, two registered dental hygienists, and two certified dental medication aides	Substantial Compliance

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	provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	Documentation of CPR certification was submitted for the Dental Department staff. Seven of seven (100%) clinical dental staff were current in CPR. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted in a document entitled: "Exams completed during 8-1-13 through 2-28-14." This was reviewed to determine timeliness of annual examination completion. The most recent two dates were taken from the list. The list included names of 142 individuals. None of these had database errors/typographical errors. New admissions in the prior year were excluded, because two dates were not available for this group of individuals. All 142 were listed with prior annual examination dates. Of these 142, 140 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 99 percent. There were currently no overdue annual examinations. The reason was provided for one of two individuals for which there was an overdue annual completed: hospitalization for over four months. The Dental Department documented that there were no individuals residing at CCSSLC who had not seen a dentist in the prior 365 day time period (i.e., 1/31/13 to 1/31/14). The content of a document submitted regarding annual dental assessments was not specifically reviewed, because there was a misunderstanding regarding the document request. The Facility submitted no copies of completed "annual dental examination" forms that were completed as part of the annual examination and treatment dental visit. Instead two sets of annual dental summaries were submitted. However, the information on the annual dental summary was more extensive than recorded in the annual dental assessment. Hence, the content of the annual dental assessment generally did not document information not already provided in the annual dental summary. The annual dental assessment form was being completed, because copies of the annual dental assessments were provided as parts of other requests. From samples obtained from these other document requests, entries included comments on behavior, oral hygiene rating, periodontal assessment/condition, oral cancer screening, summary of findings and treatment during the dental appointment (i.e., plaque, calculus, bleeding, mobility, decay, missing teeth), treatment plan, oral hygiene recommendations, and sedation provided (if applicable). A periodontal chart was provided as part of the annual dental summary. A copy of five annual dental summaries (i.e., the report submitted to the IDT for the ISP process) were submitted for review that had been completed in the 30 days prior to the Monitoring Team's visit along with the prior year's completed assessments. The content of this submitted document included the following components: ▪ Five of five (100%) submitted summaries had an entry concerning cooperation,	

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		behavioral issues, and need for sedation/restraint use. ▪ Five of five (100%) submitted summaries had entries for oral hygiene rating. ▪ Five of five (100%) submitted summaries for individuals with teeth had entries for periodontal condition. ▪ Five of five (100%) submitted summaries had entries for oral cancer screening (i.e., intra-oral exam and extra oral exam screening)/soft tissue exam. ▪ Of those with teeth, a periodontal chart or periodontal screening/probe record was completed/documented in five of five (100%). ▪ Five of five (100%) submitted summaries documented positioning requirements. ▪ Five of five (100%) submitted summaries documented a summary of findings/treatment during the annual visit. ▪ Five of five (100%) submitted summaries included a dental treatment plan/recommendations. ▪ Five of five (100%) submitted summaries documented oral hygiene/tooth-brushing recommendations. ▪ Five of five (100%) submitted summaries documented risk rating. ▪ Five of five (100%) submitted summaries documented community transition preparedness. ▪ Completion of the annual dental summary occurred from 20 to 36 days following the annual dental assessment. ▪ The five annual dental assessments for these five annual dental summaries were within 365 days of the prior annual dental assessments. The Dental Department tracked completion of annual exams on a monthly basis, and provided monthly reports with completion rates calculated. <u>New admissions</u> Additionally, during the time period from 8/1/2013 through 2/28/14, there were three new admissions. Three of three individuals had completed an initial dental exam in the first month (from eight to 10 days). One new admission received restorative work within 30 days. Two new admissions had extractions within six months of admission, indicating significant dental disease prior to admission. There were two new admissions with extractions scheduled in May 2014. <u>Oral Hygiene</u> An oral hygiene index was completed on each individual (that had teeth) at the time of the annual exam. The most recent oral hygiene scores were submitted for the entire campus, in a document entitled: "Corpus Christi State Supported Living Center Current Oral Hygiene Ratings," dated 2/3/14. According to this document, for a census of 236 individuals, this information was submitted as follows:	

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Good Oral Hygiene Rating (#/%)	Fair Oral Hygiene Rating (#/%)	Poor Oral Hygiene Rating (#/%)
123 (52%)	75 (32%)	38 (16%)

This information included both dentate and edentulous individuals. There were 19 individuals that were edentulous, according to this document. All had good oral hygiene ratings. These were removed from the following calculations to determine the percentage of oral hygiene ratings per category for those with teeth (236 – 19 = 217 individuals):

Good Oral Hygiene Rating (#/%)	Fair Oral Hygiene Rating (#/%)	Poor Oral Hygiene Rating (#/%)
104 (48%)	75 (35%)	38 (18%)

The Dental Department provided periodontal probing data or periodontal chart completion/updates in the dental record. The number of dentate individuals was listed as 211. For the seven-month time period of September 2013 through March 2014, 132 of 211 (63%) dental records included periodontal charting. Of these 132, 42 had updates completed.

Oral Hygiene Training

The Dental Department provided information concerning the number of new employees trained in oral hygiene during orientation. The following indicates the training per month and department:

Department	9/13	10/13	11/13	12/13	1/14	2/14
Residential	20	19	29	30	21	19
Other	3	1	0	1	0	0
Total	**23**	**20**	**29**	**31**	**21**	**19**

The Dental Department provided information concerning the number of individuals receiving oral hygiene instruction at the dental office (chair-side).

Dental appointments with oral hygiene instruction	9/13	10/13	11/13	12/13	1/14	2/14
# of individuals	67	73	58	48	74	52

The Dental Department provided information concerning the number of staff receiving oral hygiene instruction at the dental office (chair-side).

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Dental appointments with oral hygiene instruction	9/13	10/13	11/13	12/13	1/14	2/14
# of staff	67	78	55	48	90	65

From documentation the Dental Department submitted, oral hygiene instruction in the residences occurred for staff, but a log of data per month was not available. Dental Department staff provided training in the residences. Focus was hands-on training of staff for individuals with poor oral hygiene. Training dates on the training rosters were 8/9/13 (two shifts), 8/19/13, 8/23/13, 10/23/13, and 11/8/13. Staff that assisted 27 individuals with poor oral hygiene were trained during these sessions.

A separate document was submitted entitled: "correct number of direct support professionals manning the floor." It provided the list of staff trained in the residence during the time period from 8/1/13 through 1/31/14. Four hundred twenty eight staff were in the homes at the time of the training. Two hundred ninety three (68%) participated in the training during this six-month interval, which exceeded 50 percent of the staff.

A suggestion that the Facility should consider is developing a structured program in which dental staff provide one-on-one training in residences with individuals with poor oral hygiene scores, as well as with the direct support professionals assisting the individual with completion of oral hygiene, with creation of a database to determine which individuals with poor oral hygiene were the focus of these types of training sessions, along with dates of training. It appeared dental instruction was being appropriately provided, but it was difficult to track which individuals received this intervention without reviewing the raw data.

An annual refresher course in oral hygiene was completed through iLearn (via CTD with specific reports generated for CCSSLC). The course was listed as "Oral care iLearn." This indicated the following number of staff completed this annual refresher in the most recent six months:

	9/13	10/13	11/13	12/13	1/14	2/14
# of staff	90	87	52	35	76	29

<u>Suction Tooth-brushing</u>
As part of preventive oral care, a list was submitted indicating 35 individuals received suction tooth brushing, which was 35 out of 231 (15%) of the population. In the time period from 8/1/13 through 1/31/14, one individual had orders for suction tooth brushing discontinued due to unstable behaviors. One individual that had orders for suction tooth brushing was deceased.

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		Additionally, since the last Monitoring Team visit, seven individuals were reviewed to determine if they would benefit from suction tooth brushing. Three individuals were accepted, and had started participating in suction tooth brushing (these were counted as part of the 35 individuals mentioned above). One individual was declined suction tooth-brushing intervention, because the risk outweighed the benefit due to aggressive and uncooperative behavior. This individual was referred to the behaviorist. There were three additional individuals identified that were to be evaluated for this procedure and were to be scheduled for chlorhexidine gluconate trials with the suction toothbrush. <u>Individuals with self brushing plans</u> Sixty-seven individuals had care plans/ISPs that included brushing one's own teeth. The oral hygiene scores of the 64 individuals were submitted for the prior two ratings completed at the time of the annual exam. It was noted that the span of time varied between ratings submitted. Although requested documentation was for oral hygiene scores over the prior year, the current and prior oral hygiene scores were submitted. This interval of time was usually far less than a year apart, and often the interval was weeks to months. This would bias against any change being detected due to a short time interval. Three individuals were new admissions/readmissions and had no prior oral hygiene rating submitted from the prior year. Forty remained in the same category of oral hygiene rating. There were 30 that maintained a good oral hygiene rating. For 10, the individuals maintained a fair oral hygiene rating. No individual was noted to have a prior and current poor oral hygiene rating. For 12 individuals that brushed their own teeth, there was improvement in the oral hygiene ratings. For four individuals the ratings improved from poor to fair. For eight individuals the ratings improved from fair to good. For no individuals, the ratings improved from poor to good. For 12 individuals, the oral hygiene ratings worsened. For two individuals, the rating changed from good to poor. For nine individuals, the ratings changed from good to fair. For one individual, the ratings changed from fair to poor. An untitled list included 75 individuals that had poor oral hygiene ratings during one or more months from September 2013 through February 2014. As evidence of actions taken, the staff for 73 of 75 had staff in-service training on oral hygiene one to four times. Dates of each of the trainings were included in the document. Fifteen had staff support objectives and one had a skill acquisition plan. From a separate document, entitled: "CCSSLC Current Oral Hygiene Rating Report," dated 4/3/14, there were 33 individuals listed with poor oral hygiene. Twenty-five had staff support objectives, and seven had skill acquisition plans. It	

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		was noted that some of the objectives had been in place many months (one dating back to 8/28/12). It is suggested that the Dental Department and IDT review such plans, when the oral hygiene score deteriorates or remains poor, in order to develop a plan with positive impact. However, it was positive that since the last review, the Dental had focused efforts on training staff to assist in improving oral hygiene ratings. Flossing The Dental Department listed 45 individuals that had the potential to floss independently. The criteria were the individual allowed flossing during dental office visits, had the dexterity to complete the task, the ability to brush their teeth independently, and the potential to floss independently. Individuals were trained on two methods of flossing (i.e., regular floss and dental pic). Training was done in the dental office. Twenty-five of 35 chose a preferred method of flossing. Flossing was not a formally established procedure at CCSSLC outside of the dental office, due to a history of adverse events while flossing. Flossing continued to occur during the dental visit. The Facility is continued to be encouraged to expand this to the residences. Pneumonia The Facility submitted a list of those with a diagnosis of pneumonia from 8/1/13 through 1/31/14, along with the date of the dental appointment prior to the pneumonia, and the procedure completed during that appointment. Of a list of individuals that had a diagnosis of 31 pneumonias, no individuals had dental appointments within eight days prior to the date of the pneumonia diagnosis. Preventive, Restorative, Emergency Dental Services The Dental Department provided the breadth of services required to care for the individuals at CCSSLC. From 8/1/2013 through 2/28/14, there were 302 appointments for prophylactic care. A document entitled: "Preventative Care Provided" was submitted. These visits occurred as prophylactic care only treatment or as a combination of other dental services (i.e., annual assessments, x-rays, topical fluoride treatment, etc.). The following was the breakdown per month of the number of prophylactic care treatments completed: **Month** | **Number of Prophylactic Care Treatments** August 2013 | 51 September 2013 | 42 October 2013 | 49 November 2013 | 36	

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December 2013	32
January 2014	51
February 2014	41
Total	**302**

Fourteen individuals underwent restorative care during 14 appointments. For four individuals, community oral surgeons were consulted. The following was the number of restorations completed at each visit, along with the number of visits in which this occurred:

Number of Restorations Per Visit	Number of Visits	Number of Restorations Per Visit	Number of Visits
1	5	5	2
2	3	6	0
3	2	7	1
4	0	8	0
		9	1
Total:	**43 restorations**		

The following were the number of visits per month for restorations, and the total number of restorations completed per month:

Month	Number of Visits	Number of Restorations Per Visit	Total Number of Restorations For Month
August 2013	1	1	1
September 2013	4	1 to 5	9
October 2013	1	2	2
November 2013	1	2	2
December 2013	3	1 to 9	13
January 2014	3	3 to 7	15
February 2014	1	1	1
Total	**14**		**43**

A document entitled: "Dental Emergency Log 08/01/2013 through 02/28/14" with run date 3/11/14 documented that 17 individuals were seen and treated for 26 dental emergencies. The following information was derived from this document:

Month	Number of Emergencies	Resolved	Month	Number of Emergencies	Resolved

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August 2013	4	4	September 2013	1	1
October 2013	4	4	November 2013	4	4
December 2013	1	1	January 2014	6	6
February 2014	6	5 (1 pending)	**Total**	**26**	**25**

Information was also provided indicating timely response to dental emergencies:

Month	Number of Emergencies	Seen Same Day	Seen Next Work Day	Month	Number of Emergencies	Seen Same Day	Seen Next Work Day
August 2013	4	3	1	September 2013	1	1	0
October 2013	4	3	0	November 2013	4	4	0
December 2013	1	0	1	January 2014	6	4	2
February 2014	6	3	2				

From a document entitled "Extraction Report: All Practitioners" (report generated 3/4/14), 20 individuals underwent dental extractions. The number of teeth extracted per individual ranged from one to 21 per visit. Twenty individuals had 74 teeth extracted. The following information provided the breakdown by visit and numbers of teeth extracted per visit:

Month	Number of Visits with Extractions	1 Tooth Extracted	2 Teeth Extracted	3 Teeth Extracted	4 Teeth Extracted	5 or More Teeth Extracted
August 2013	2	1	0	0	1	0
September 2013	1	0	1	0	0	0
October 2013	3	1	0	1	1	0
November	4	3	0	0	0	1

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2013						
December 2013	2	0	0	0	1	1
January 2014	6	1	1	0	3	1
February 2014	2	2	0	0	0	0
Total	**20**	**8**	**2**	**1**	**6**	**3**

From a submitted document, annual exams were done as the only procedure, or were completed in combination with prophylactic treatment, x-rays, consultations, etc. The following number of annual exams were completed per month:

Month	Number of Completed Annual Exams
August 2013	10
September 2013	16
October 2013	16
November 2013	12
December 2013	15
January 2014	15
February 2014	20
Total	**104**

Month	Number of Completed Annual Exams during month within 365 days of prior exam	Number of Completed Annual Exams past 365 days of prior exam
August 2013	15	0
September 2013	18	0
October 2013	24	1
November 2013	15	0
December 2013	14	0
January 2014	39	1
Total	**125**	**2**

<u>X-rays</u>
The Dental Department referred to American Dental Association guidelines of 2004 in prioritizing the need for ordering x-rays. Those individuals with an outstanding need of dental x-rays were categorized as follows:

- Category A – "Low priority, oral hygiene good/fair, no visible decay, severe bruxism,

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		unable to stay still for x-rays, safety concerns such as pica or self injurious behavior, limited dentition." There were nine individuals listed in this category, which indicated progress in this area, because there were 12 listed in the Monitoring Team's report from October 2013. It was documented that all had dental evaluations in the past year as of 2/10/14. It was noted that eight of nine had full mouth series x-rays completed in the past, but not in the prior three years. Information concerning IDT discussion or second dental opinion to determine risk/benefit ratio was not submitted or reviewed, but it appeared there was progress in reducing the number of applicable individuals that did not have routine dental films. ▪ Category B – "Medium priority, oral hygiene fair/poor, combative, pending TIVA candidate, psychotic, irrational behavior, frequently refuses dental services, ability to cooperate present." There were no individuals listed in this category. ▪ Category C – "High priority, oral hygiene poor, decay present, mobility present, eminent need for dental restorations and/or extractions, new admissions." There were no individuals listed in this category. ▪ Category 0 – "No ability to take x-rays, anatomy of the oral cavity, medically compromised, contraindicated for TIVA dentistry, fixation of the temporo-mandibular joint, fragile health, serious or terminal health condition, compromised airway." There were 15 individuals listed in this category. It was noted that all had been seen in the past year as of 2/10/14. ▪ There were no new admissions that needed to have x-rays completed. ▪ Overall, 207/231 (90%) individuals completed dental x-rays according to American Dental Association guidelines. <u>Edentulous Individuals/Dentures</u> Information submitted in a document entitled: "Edentulous List" indicated 19 individuals residing at CCSSLC were edentulous, for a rate of 19 of 231 (8%). One of the nineteen individuals had become edentulous in the prior six months. ▪ Five individuals had dentures. All had mixed dentition. No individual that was edentulous had complete dentures. These five were not listed with the 19 edentulous individuals as they had partial dentition. ▪ Nineteen individuals that were edentulous did not have dentures. Reasons given were: o Nineteen: inadequate cooperation for denture fabrication to be completed; o Nine: complex oral anatomy; o Zero: inadequate muscle coordination, uncontrolled muscle movements, or excessive gag reflex; o Zero: refused dentures when offered; o Zero: prior poor dental experience; and o Zero: undergoing dental procedures, which might lead to dentures in the	

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future.
- Some individuals had more than one reason listed for not having dentures.

Oral Sedation

Monitoring and evaluation of use of oral sedation was reviewed. Five active records were submitted for individuals who underwent oral sedation. The following summarizes the results of this review:

- Five of five confirmed nothing by mouth (NPO) status or nothing per G-tube at the time of the dental visit.
- Five of five (100%) listed the medication administered, the dose, and the route.
- Five of five (100%) listed pre-procedure vital signs in the home.
- Five of five (100%) had an examination note/operative IPN/Dental Progress Note (DPN) on the date of the visit.
- Five of five (100%) documented pre-procedure vital signs at the dental office.
- Five of five (100%) documented post-procedure vital signs.
- Adequate documentation regarding effectiveness of sedation was found in five of five (100%) of the active records.
- Five of five (100%) documented Dental Department follow-up (i.e., phone or visit) the next business day.
- Five of five documented a post dental procedure IPN note.
- Five of five (100%) included documentation of current sedation consent from guardian/ Legally Authorized Representative (LAR).
- Five of five (100%) included documentation of HRC review and approval.
- Five of five (100%) included a restraint checklist.

General Anesthesia/TIVA

The Dental Department submitted the general anesthesia/TIVA appointment schedule for the time period 8/1/13 through 2/28/14. The number of appointments utilizing general anesthesia/TIVA completed per month follow:

Month	Number of Completed Visits with General Anesthesia/TIVA	Number of Scheduled Visits with General Anesthesia/TIVA Not Completed	Completed at Second Appointment	TIVA Appointment Not Completed
August 2013	4	0	N/A	N/A
September 2013	8	0	N/A	N/A
October	5	0	N/A	N/A

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2013					
November 2013	5	0	N/A	N/A	
December 2103	7	0	N/A	N/A	
January 2014	8	1	0	1	
February 2014	2	2	1	1	
Total	**39**	**3**	**1**	**2**	

Thirty-six of 39 (92%) completed the initial TIVA appointment.

The active record was submitted for five individuals who had undergone general anesthesia/TIVA during January and February 2014. The procedures under general anesthesia/TIVA included one or more aspect of dental care. The list varied in each case, and included one or more of the following: x-rays, restorations, extractions, annual exam, and prophylactic care. Review of these records revealed the following:

- Consent by the guardian/LAR for the dental procedures/anesthesia was current (i.e., defined as completed and dated within 365 days of the procedure) in five of five (100%).
- A copy of the HRC review and approval was submitted in five of five (100%).
- A pre-operative medical clearance was completed and submitted in five of five (100%) cases.
- A pre-operative anesthesia record/clearance by anesthesia was completed and submitted in five of five (100%).
- Pre-operative vital signs were recorded or attempted in five of five (100%) cases.
- An operative note by the dentist was recorded in five of five (100%) cases.
- The operative anesthesia record was completed in five of five (100%) cases.
- For those with teeth, a periodontal chart/periodontal screening record was submitted for five of five (100%) cases.
- The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score, Aldrete Score, or other equivalent assessment was submitted in five of five (100%) of the active records.
- An Infirmary recovery/post-operative note was submitted for five of five (100%).
- Post-operative vital signs were submitted in five of five (100%).
- Pain medication was prescribed in one of two cases in which extractions occurred.
- An annual dental assessment was completed while under general anesthesia/TIVA in five of five (100%) cases.

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		The Facility provided information concerning injuries reported within 24 hours of general anesthesia/TIVA administration. For the time period 8/1/13 through 1/31/14, there were 36 appointments completed for individuals listed as having been scheduled for general anesthesia/TIVA. For these 36 appointments, there were no injuries reported in the following 24-hour time period. <u>Extractions</u> For five individuals that underwent extractions on campus, the dental record was submitted. The following findings were made: ▪ From the submitted documentation, guardian/LAR consent was current in five of five (100%). ▪ A dental IPN/DPN indicating the need for extractions was documented in five of five (100%), either completed pre-operatively or at the time of exam under general anesthesia/TIVA. ▪ For five of five cases, IV sedation/general anesthesia was used. ▪ From one to four teeth were extracted at a visit. ▪ Pain medication was provided in three of five cases. ▪ A follow-up dental note the following morning in the Infirmary or a phone call to the residence (when not admitted overnight to the Infirmary) was documented in five of five (100%) cases. ▪ A follow-up visit was documented in five of five (100%) cases to determine healing or complications. For five individuals that underwent oral surgery consultation off campus, the dental record was submitted. The following findings were noted: ▪ Five of five (100%) had completed IPN/DPNs in the record prior to referral to the oral surgeon indicating the need for the procedure. ▪ Five of five (100%) had a post procedure note by a CCSSLC dentist at the Facility the following day. ▪ Five of five (100%) included an oral surgery consult report. ▪ An anesthesia report (including medication and dosage administered) was submitted for five of five (100%). ▪ A copy of the current consent by the guardian/LAR was submitted for five of five (100%) of these oral surgeries. <u>Emergency Treatment</u> The "Dental Emergency Log" tracked emergencies to closure. Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: self-inflicted blister on lip, discomfort when swallowing, mouth ulcer, dental discomfort, and dental sensitivity. The following findings are made based on this review: ▪ Five of five (100%) records documented the presence, or not, of pain.	

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		▪ Pain was treated in two of five cases. ▪ Follow-up occurred for two individuals. Follow-up was not indicated for three individuals. ▪ There was documentation of closure of the dental emergency (i.e., either no further visit required or scheduled for procedure) in five of five (100%) cases. ▪ The length of time from the notification of the dental emergency in the Dental Department to completing a visit varied. All occurred within 24 hours. Four of five occurred within two hours. One occurred within 18 hours.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	This section of the report includes a number of sections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Policies and Procedures</u> Policies developed and implemented since the last Monitoring Team visit included the following: ▪ "SSLC Policy: Dental Services," Policy #015.1, dated 8/15/13. This provided updated language and removal of several definitions. Policy development remained outstanding for several dental services (e.g., tracking periodontitis, tracking of oral hygiene for those that independently brush their teeth, etc.) The Monitoring Team's previous report for this section listed areas needing policy development. <u>Provision of Dental Records to IDT</u> Copies of the most recent comprehensive exams from the active record were requested for one individual from each residence along with the copy from the dental office records. This was used to assist in determining whether the IDTs received adequate/complete dental information for the individuals. Documentation for 13 individuals was submitted and included the following: 136 documents were located in the dental record at the dental office. One hundred thirty-three documents were located in the dental section of the active record. This was a compliance rate of 133 of 136 (98%). A member of the Dental Department attended ISPs (i.e., annuals) when they were considered required. As mentioned with regard to Section G.1, the data did not reflect the number of required meetings. There were several meetings for which the individual had good to fair oral hygiene, yet the roster indicated required attendance. It was not clear if these individuals had other dental risks (e.g., use of general anesthesia, need for desensitization, etc.) that would have required dental staff attendance. Additionally, the Dental Department was unable to attend when TIVA appointments were scheduled (usually for the entire day,	Noncompliance

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		determined by the consultant's schedule). An alternative to attendance (i.e., completed report and prior meeting with QIDP) might provide the needed information. As TIVA appointments are scheduled in advance, if a dentist is required at an ISP, then the QIDP should ensure there is no conflict with the TIVA schedule. The attendance rate for required ISPs in March 2014 was 86 percent. It was not determined whether these were all clinically required. Refusals/Missed Appointments A review of information from a document entitled: "Individuals Identified to have refused Dental Treatment" for dental appointments from 8/1/13 through 2/28/14 indicated that 25 individuals refused 27 initial appointments. Additionally, 17 follow-up appointments scheduled to complete the initial appointments were refused. ▪ Twenty-one follow-up appointments for initial appointments were subsequently completed. ▪ Six follow-up appointments for initial appointments were still pending/remained incomplete (the document run date was 3/4/13). ▪ Three appointments were refused and not rescheduled (the reason provided was "need to have IDT involved" in two of three cases). Thirteen individuals refused more than one appointment. Reasons for the scheduled appointments that were refused included: prophylaxis (16 appointments), TIVA dentistry (three appointments), annual (four appointments), annual and prophylaxis (one appointment), exam not otherwise specified (one appointment), and restoration (one with TIVA and one with pre-sedation).	

Month	Number of Refused Appointments
August 2013	8
September 2013	8
October 2013	10
November 2013	7
December 2013	5
January 2014	3
February 2014	3
Total	**44**

For the 27 initial appointments that were refused, a follow-up appointment was completed in 21 cases.
- For nine individuals, the completed appointments occurred from one to 15 days after the refused appointment.
- For three individuals, the completed appointments occurred from 16 to 30 days

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		after the refused appointment. ▪ For five individuals, the completed appointment occurred from 31 to 60 days after the refused appointment. ▪ For four individuals, the completed appointment occurred more than 60 days after the refused appointment. ▪ Six individuals had a refused appointment for which a completed appointment had not yet occurred by the time of the printing of the document. <u>Non-refusals/Missed appointments</u> For the time period 8/1/13 through 2/28/14, there were 33 missed/no show appointments that were not categorized as refusals. Reasons for the scheduled appointments that were missed included prophylaxis (19 appointments), periodic exam (one appointment), annual exam (six appointments), annual exam and prophylaxis (four appointments), prophylaxis and x-rays (zero appointments), extractions (zero appointments), tooth-brushing instruction (one appointment), desensitization trial (one appointment), and restorations (one appointment). The major reasons identified for the initial missed appointments included: medical illness (18), staffing issue in the residence (four), furlough (three), dental clinic reason (two), inclement weather (two), nursing issue (two), schedule conflict (one), and behavior (one).	

Month	Number of Missed Appointments, Initial and Missed Follow-Up Appointments (Non-refusals)
August 2013	7
September 2013	9
October 2013	12
November 2013	3
December 2013	7
January 2014	6
February 2014	2
Total	**46**

For the 33 initial appointments that were missed, a follow-up appointment was documented in 29 cases. Three individuals missed a follow-up appointment for completion. Two of these were due to ongoing medical illness requiring hospitalization, one moved from the Facility, and one was pending an appointment in the future (i.e., after run date of 3/4/14).

- For 17 individuals, the completed appointments occurred from six to 15 days after the missed appointment.
- For four individuals, the completed appointments occurred from 16 to 30 days after

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		the missed appointment. ▪ For five individuals, the completed appointment occurred from 31 to 60 days after the missed appointment. ▪ For three individuals, the completed appointment occurred more than 60 days after the missed appointment. From a document entitled: "CCSSLC Dental Services Department – Monthly Trending Report," the percentage attendance of appointments was tracked on a monthly basis. For all appointments, the percentage attendance per month was as follows: **Month** / **% Attendance of All Appointments** / **Month** / **% Attendance of All Appointments** September 2013 / 65/81 = 80% / December 2013 / 68/80 = 85% October 2013 / 112/131 = 85% / January 2014 / 113/126 = 90% November 2013 / 88/98 = 90% / February 2014 / 109/117 = 93% This was a total of 555/633 (88%) appointments completed (show rate). Of these, 44/633 (7%) were refusals, 1/633 (0.2%) was a no show, and 29/633 (5%) were cancelled. The Facility had four systems in place to track missed dental appointments. On a weekly basis, the Dental Department emailed the residential units a list of individuals that had missed appointments, including whether the appointment was refused, a "no show," or cancelled. The Dental Department also tracked missed dental appointments through a database entitled: "ISPA/Monthly Refusals Tracking Chart." Three categories of the ISPA process were tracked: when an ISPA was completed and addressed the concern, when an ISPA was completed but did not address the concern, and when an ISPA was still outstanding. The tracking was color-coded for quick identification of each of these categories. A second system was the CCSSLC database for the daily morning report that included refused/missed appointments. This information was sent overnight for the residential units to have available during the Unit Incident Management Review Team Meeting, specifically located in their daily minutes under the section "Refusals: Dental." A third systems approach involved providing the list of missed dental appointments on the annual dental summary form. The Dental Department attached an additional document, "Annual Dental Summary: Missed: no show/cancelled/refusal Appointment Log," which provided an updated list of missed appointments for all reasons to the IDT. The fourth system was newly implemented in November 2013. The "Integrated Monthly	

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		Review" form included an area dedicated to updates for "medical/dental appointment refusals." The QIDP Coordinator and the Program Review Committee monitored the completion/content of this form. <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u> Information was submitted concerning use of restraints for dental procedures. For the prior six months (i.e., 8/1/13 through 2/28/14), there were 754 completed appointments during which the dental office did not use mechanical restraints. Seven of 754 (1%) completed appointments utilized oral sedation. Thirty-eight of 754 (5%) completed appointments utilized general anesthesia/TIVA. The following table lists this information by month:	

Month	Completed Appointments	# of appts with TIVA/GA	% appts with TIVA/GA	# of appts with oral sedation	% appts with oral sedation
August 2013	121	3	2%	1	1%
September 2013	81	8	10%	2	2%
October 2013	131	5	4%	1	1%
November 2013	98	5	5%	1	1%
December 2013	80	7	9%	1	1%
January 2014	126	8	6%	0	0%
February 2014	117	2	2%	1	1%
Total	**754**	**38**	**5%**	**7**	**1%**

Separately, a list of HRC-approved dental and medical restraints was submitted, including the use of sedation. A total of 55 individuals were listed that required dental sedation. Of these, 37 had HRC approval for general anesthesia/TIVA, six had HRC approval for oral sedation, and 12 had HRC approval for sedation during oral surgery off-site. Fifty-four of 55 (98%) had current HRC approvals. For one individual that underwent oral sedation, the submitted document was outdated.

The Dental Department maintained a database entitled: "Dental Sedation usage Report." For

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		each dental appointment requiring sedation, this chronological list included the individual's name, date of appointment, the medication and dosage given, and the effectiveness of the medication. Separately, the Dental Department maintained a historical log of information entitled: "Individual Sedation Report," which dated back to September 2010. For each individual that required sedation for a dental appointment, the date, medication, dosage, and, if indicated, the length of time administered prior to the dental appointment. Effectiveness was also recorded. These two reports provided the necessary information to order the appropriate medication and dosage of medication for the individual according to prior effectiveness. <u>Desensitization</u> The Dental Department submitted several documents related to desensitization. A document entitled: "Dental Desensitization (Rehearsal) Steps" identified the 27 steps used in the task analysis process. Submitted was a "Tracking Sheet of Baseline Trial Groups" that was completed by the Dental Department (not the Psychology Department). Fifty-five names were listed and of these 55, one had a completed task analysis and a desensitization plan was pending. Eleven had desensitization plans implemented, with date of implementation (9/15/13, 10/21/13, or 2/3/14). Twenty individuals were listed as "not a candidate for desensitization plan." Twenty-two were listed as "working" under the heading "Task Analysis," and the highest step of the current analysis was listed. Eleven desensitization plans were submitted. For two, the dental desensitization plan was being completed in the residence by Behavioral Health Services. The plan for these two was not available. Monthly QIDP reports were submitted for each of these that included information concerning progress being made in the desensitization plans. ▪ There was one desensitization plan being developed. ▪ Fourteen individuals had a medical desensitization plan only (13 of these were edentulous). ▪ One hundred forty four individuals were not considered to be candidates for a desensitization plan. o Thirty-three of the 144 only needed rest (this term was not further clarified) in completing a routine appointment. o Thirty-five of the 144 needed sedation for a routine appointment. o For the remaining 76, no information was provided for the categorization of "not a desensitization candidate." o Separately, a document entitled "Individuals Deemed Inappropriate for Dental Desensitization Plans per Behavior Sciences" listed 27 individuals. Reasons were listed as: physiological spasticity (11), physiological (one),	

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		and no sedation for routine procedures (15). From a document entitled: "CCSSLC Individuals with Desensitization Plans," desensitization trial progress reports were listed in monthly charts from November 2013 through February 2014. At the time of the Monitoring Team's visit, an updated document was provided entitled: "CCSSLC Individuals with Desensitization Plans/Desensitization Trials between 10/1/13 and 3/31/14." In the table below, the one discrepancy noted is in parentheses from the document provided on site. The Dental Department had the following number of appointments for desensitization per month:	

Month	# of individuals	# of appointments	# of successes*
November 2013	3	20	14
December 2013	3	18	16
January 2014	3	23 (24)	20
February 2014	9	53	43
March 2014	8	68	15

*Success was defined as progress through at least one step in the plan.

A document with updated desensitization/behavioral plan status/progress was provided on site during the Monitoring Team's visit. The following information was derived from this updated information:

- A desensitization/other behavioral plan was considered appropriate for 75 individuals.
- A desensitization/other behavioral plan was considered inappropriate for 156 individuals. This was the Facility's assessment, and as discussed in other sections of this report, needed review.
- Twenty-one individuals had a desensitization/other behavioral plan in draft stage.
- Eleven individuals had a desensitization/other behavioral plan completed.
- Eleven individuals had a desensitization/ other behavioral plan implemented.
    - As of 3/31/14, it was noted seven plans had been implemented one to three months, four plans had been implemented four to six months, and no plan had been implemented longer than six months.
- Eleven individuals had a desensitization/other behavioral plan in which data was analyzed and results were available.
- One individual had a desensitization/other behavioral plan revised based on analysis of collected data due to lack of progress/regression.
- There was no information available whether any of the other 10 implemented desensitization/other behavioral plans had indicated progress, no progress, or variable progress.
- No individual with an implemented desensitization/other behavioral plan had

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		moved to the community. It is recommended that reasons for not being eligible for desensitization or behavioral plans be included in the database. The Dental Department should have information as to the reason for each individual not being a candidate for a desensitization/behavioral plan. <u>Internal Dental Department Improvement Initiatives</u> The Dental Department submitted a document entitled: "CCSSLC Quality Indicators" for Section Q. There were a number of new quality indicators added to address the oral health of the individuals being served. The focus of the new quality indicators on the clinical care of the individual appeared to be more outcome-oriented, rather than process oriented. New quality indicators submitted included the following: ▪ Number of individuals with new decay; ▪ Number of individuals with healthy tissue; ▪ Number of individuals with gingivitis; ▪ Number of individuals with incipient periodontitis; ▪ Number of individuals with moderate periodontitis; ▪ Number of individuals with severe periodontitis; ▪ Percentage of individuals whose periodontal conditions improved; ▪ Percentage of individuals whose periodontal conditions remained stable; ▪ Percentage of individuals whose periodontal conditions advanced; and ▪ Number of individuals that had extractions and total number of teeth that were removed. The date of implementation of these clinical indicators appeared to be 11/1/13, based on submitted data. Data was collected monthly. It is recommended that clear definitions or parameters for each of the dental terms be provided with the database analysis, and methodologies for measuring the indicators be clearly defined. The Dental Department had numerous databases to track the activities of the department and examples included the following: ▪ Tracking timely completion of the annual assessment by the provider within 30 days of the completed examination and reviewed by peer provider within seven days thereafter; ▪ ISPA/Monthly Refusals Tracking Chart; ▪ Oral hygiene rating report that listed whether a SAP/SSO existed and start date of the plan; ▪ Individuals with desensitization plans with dates of appointment, the step of the plan attempted, and whether the plan was successful for that step. (This database expanded the fields to provide more information concerning progress);	

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		▪ Oral hygiene ratings recorded per month; ▪ Monthly trending reports, quarterly trending reports; ▪ Dental appointments – refusals; ▪ Rights Tracking Spreadsheet for sedation; ▪ NPO status documentation for TIVA cases; ▪ Community supports mentioned in Community Living Discharge Plan (CLDP); ▪ Timely submission of assessments for ISP process; ▪ Psychology Master Desensitization Need List; ▪ Annuals completed last year timely; ▪ New admissions – dental services provided; ▪ Oral cancer screening conducted; ▪ Review of records for treatment plans; ▪ Individuals and or staff that received tooth brushing instruction at dental visit; ▪ Individuals that received preventive services; ▪ Dental emergency log per month; ▪ Extraction report – all practitioners; and ▪ Post dental extraction follow-up. Corrective action plans generated from the QA/QI analysis included development of a CAP for dental appointment refusals and a desensitization plan process. The Dental Department generated Quarterly reports for dental QI and submitted them to the QA/QI Council (10/24/14 and 1/24/14).	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Presentation Book for Section R; o For 20 individuals (i.e., Individual #147, Individual #137, Individual #40, Individual #268, Individual #136, Individual #58, Individual #298, Individual #305, Individual #141, Individual #21, Individual #369, Individual #367, Individual #272, Individual #312, Individual #22, Individual #315, Individual #229, Individual #68, Individual #67, and Individual #356), the following documents: Communication Comprehensive assessment; Update and Assessment of Current Status; ISP and ISPAs for past year; Positive Behavior Support Plan; skill acquisition programs related to communication and supporting documentation for implementation (indirect supports); direct SLP therapy intervention plans and supporting documentation such as IPNs, or monthly reviews by SLP; alternative and augmentative communication (AAC) programs, and supporting documentation for implementation of indirect supports; individual-specific communication monitoring for past six months; and evidence of effectiveness monitoring for SLP interventions (direct) and programs (indirect); o SLP assessments for three individuals newly admitted to CCSSLC: Individual #35, Individual #45, and Individual #78; o Policy and procedures addressing the provision of speech and/or communication services and supports, including changes since the Monitoring Team's last visit; o Continuing education and other training completed by SLPs with certificates of completion, since the Monitoring Team's last visit; o List of current SLP and audiology staff along with corresponding caseloads, and CVs for newly hired SLPs; o List of individuals with AAC devices; o Communication Master Plan List; o AAC Screening forms; o Speech language (SL) comprehensive assessments and updates (templates) used by SLPs along with any changes; o Tracking Log of SL assessments completed since Monitoring Team's last review; o Monitoring forms used by SLPs, Speech Language Pathology Assistants (SLPAs), and PNMP Coordinators; o Copies of blank communication competency-based performance check-off sheets for new employees; o Inter-rater reliability compliance scores and corresponding audits; o List of individuals receiving direct speech services and focus of intervention; o List of individuals with behavioral issues and coexisting severe language deficits, and risk level/status for challenging behavior; o List of individuals with PBSPs and replacement behaviors related to communication; o Minutes for Communication committee meetings held since the Monitoring Team's last

	review; o Minutes for Speech Department meetings held since the Monitoring Team's last review; o List of all general common area communication devices; o Blank communication competency-based performance check-off for individual-specific communication programs; o Completed audits of SLP documentation; and o Behavior Support Committee minutes and attendance sign-in sheets for meetings held since the Monitoring Team's last review. ▪ **Interviews with:** o Nancee Dixon, Section R Lead; o Bryanna Gutierrez, SLP; and o Melissa Grothe, SLP. ▪ **Observations of:** o Individuals with AAC devices in residences and day programs.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 3/14/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. Based on a review of the Facility Self-Assessment, as well as interview with the Director of HT, the following was found: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section R. The results were presented at the QA/QI Council meeting to facilitate integration amongst the different Plan of Improvement sections. Based on interview with the SLP Lead and the assigned Program Compliance Monitor for Section R, this monitoring tool was being revised. In addition, multiple Facility-developed audit tools (i.e., SLP staffing model, and SLP assessment) and HT database reports were implemented to assess compliance. ▪ The monitoring tool and audits did include adequate methodologies (e.g., observations, record review, and staff interview). ▪ The Self-Assessment identified the sample sizes, including sample sizes adequate to consider them representative. Section R samples were generated utilizing a Random Sample Generator. ▪ The Facility-based audit tools (i.e., SLP assessment audit tool) did not include adequate instructions, including methodologies, standards, and criteria. ▪ The following staff/positions were responsible for the Settlement Agreement Monitoring Tool for Section R: the Director of HT, Section R Lead, SLPs, and a Facility PCM. ▪ Adequate inter-rater reliability had not been established between the SLP Lead, SLPs, and the PCM. ▪ The data presented in the Self-Assessment reflected the completion of additional activities, such as tracking the completion of SLP assessments for individuals newly admitted to the Facility, using Protocol/Guideline to identify appropriate caseloads, review of current licensure and ASHA certification for SLPs, review of continuing education database, review of QIDP database for completion of assessments and attendance, etc.

	▪ The Facility presented some data in a meaningful/useful way. Specifically, the Facility's Self-Assessment presented findings consistently based on specific indicators within subsections. ▪ The Facility rated itself as being in substantial compliance with Sections R.1 and R.2. This was consistent with Monitoring Team's findings. The Facility rated itself as not being in compliance with Sections R.3 and R.4, which also was consistent with the Monitoring Team's findings. ▪ The Facility's data identified areas in need of improvement. The Director of HT and the Facility PCM provided an analysis of the Section R Monitoring results that identified the potential causes for the issues with plans to ameliorate noncompliance findings.
	Summary of Monitor's Assessment: The Facility had established a procedure that memorialized the process for determining Speech Language Pathologist assignments and responsibilities. There were an adequate number of SLPs with specialized training or experience demonstrating competence in augmentative and alternative communication to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. The SLPs were licensed to practice in the state of Texas and provided evidence of current American Speech-Language and Hearing Association (ASHA) certification. SLPs had completed continuing education directly related to communication and transferrable to the population served. The Facility SLP policies and protocols included necessary components. The Facility was found to be in substantial compliance with Section R.1. Individuals who had been newly admitted to CCSSLC had a SLP screening and/or assessment completed within 30 days, SL/communication assessments included necessary components, and SLPs and Psychologists/Behavioral Health Specialists were collaborating in the development of individual-specific communication strategies for behavioral support/interventions. The Facility was found to be in substantial compliance with Section R.2. It was very positive that observations of individuals with AAC devices showed individuals had their equipment and were using it, with staff assistance as necessary. ISPs generally provided some description of individuals' communication skills. However, additional work was needed to include descriptions of individuals' AAC systems and strategies for their use, as well as communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. Individual-specific training and performance check-offs had been developed and implemented. However, the Facility had not finalized a process to identify the total number of staff who required individual-specific training and the total number of staff who had successfully completed competency-based performance check-offs. The Facility had policies/procedures that incorporated the elements necessary for monitoring communication supports. Individuals with AAC systems had not been monitored on a consistent basis using the Monthly Person-Specific PNMP Check Sheet. Since the last review, the completion of Communication Monitoring had significantly improved. However, a review of individual-specific monitoring forms indicated multiple areas of staff noncompliance. The Facility Self-Assessment stated: "this provision is not in compliance but is improving greatly." The Monitoring Team agreed with this statement.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Samples for Section R:** ▪ **Sample R.1:** Individuals identified by the Facility with expressive or receptive language disorders with assessments completed in the last 12 months, including the following 10 individuals: Individual #272, Individual #312, Individual #22, Individual #315, Individual #229, Individual #68, Individual #67, Individual #356, Individual #147, and Individual #137; ▪ **Sample R.2:** Five individuals receiving direct speech interventions including: Individual #147, Individual #137, Individual #40, Individual #268, and Individual #136; ▪ **Sample R.3:** Seven individuals with a PBSP and communication deficits, including: Individual #58, Individual #298, Individual #305, Individual #141, Individual #321, Individual #369 and Individual #367; and ▪ **Sample R.4**: Nine individuals with AAC devices including: Individual #147, Individual #137, Individual #40, Individual #268, Individual #136, Individual #58, Individual #298, Individual #305, and Individual #367. This paragraph of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R. This section of the report addresses compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. The SLP assessment process and the development and implementation of programs are discussed with regard to Section R.2. Staff training is addressed with regard to Section R.3, and the Facility's monitoring system is discussed with regard to Section R.4. **Staffing** In November and December 2013, the Facility established SLP staffing according to the state recommended ratio of one clinician to 60 individuals. The specific criteria for the CCSSLC SLPs caseloads was as follows: ▪ SLP 1- responds to issues (evaluations, consults, therapy, training, monitoring) with an average caseload of 60 individuals; ▪ SLP 2 - responds to issues (evaluations, consults, therapy, training, monitoring) with an average caseload of 60 individuals; ▪ SLP 3 - responds to issues (evaluations, consults, therapy, training, monitoring) with an average caseload of 60 individuals; ▪ SLP 4 – responds to issues (evaluations, consults, therapy, training, monitoring, swallowing, PNMT) with an average caseload of 15 to 20 individuals; ▪ SLP 5 – responds to issues (evaluations, consults, discharges, training, mentoring, swallowing) with an average caseload of 10-15 individuals; ▪ SLP 6a – responds to issues (evaluations, consults, admissions, monitoring) with	Substantial Compliance

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		an average caseload of 20 individuals; and ▪ SLP 6b – responds to issues (AAC, consults, training, mentoring, monitoring) with an average caseload of 20 individuals. Specific caseloads had not been delegated (i.e., individuals assigned to specific SLPs) in order to allow flexibility in meeting individuals' needs. However, SLPs 1, 2 and 3 had general oversight of the three main units – Atlantic, Pacific, and Coral Sea. Evaluations were delegated based on the primary needs of the individual and/or the expertise of the SLP. All clinicians provided services in any area needed related to communication. In addition, two Speech Language Assistants provided services and support in all areas. A review of the CCSSLC policies and SLP caseloads (as well as other information discussed below) indicated there were an adequate number of SLPs with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. **Qualifications:** ▪ Six of six SLPs were licensed to practice in the state of Texas. ▪ Six of six SLPs had evidence of ASHA certification. **Continuing Education** Six of the six SLPs had completed continuing education directly related to communication and transferrable to the population served. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. The continuing education the clinicians attended included the following topics: ▪ AAC Evaluations: Painting a Successful Submission (7/23/13); ▪ Pediatric Dysphagia: Management of the Whole Child (8/28/13); ▪ 22nd Annual Texas Autism Conference (10/17/13); ▪ Annual Habilitation Therapies Conference (10/30/13); ▪ Switch Assessment (11/12/13); ▪ Effective Sensory Diets (11/20/13); ▪ AAC Annual Conference (1/30/14); and ▪ Assistive Technology Industry Association (1/29/14). **Facility Policy** The Facility submitted the following policies: ▪ CCSSLC Communication Services Guidelines: Admissions, revision date 1/31/14; ▪ CCSSLC Communication Services Guidelines: Communication Dictionary Changes, implementation date 1/31/14; ▪ CCSSLC Communication Services Guidelines: Communication Supports Auditing,	

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		implementation date 1/31/14; ▪ CCSSLC Communication Services Guidelines: Making Communication Revisions to the PNMP, implementation date 1/31/14; ▪ CCSSLC Communication Services Guidelines: ISP Preparation, revision date 1/31/14; ▪ CCSSLC Communication Services Guidelines: Applying Photo to Word Document, implementation date 1/22/14; ▪ CCSSLC Communication Services Guidelines: How to Preserve Custom Symbols and Boards in Boardmaker, revision dated 1/23/14; ▪ CCCSSLC Communication Services Guidelines: Issuing a Communication Device, implementation date 1/23/14; ▪ CCSSLC Communication Services Guidelines: Communication Consult, implementation date 1/23/14; ▪ CCSSLC Communication Services Guidelines: SLP Assessment Process, implementation date 1/23/14; ▪ CCSSLC Communication Services Guidelines: Format for Saving Client Files for Speech Communication, implementation date 1/23/14; ▪ CCSSLC Communication Supports Monitoring Guideline, dated 7/8/13; ▪ CCSSLC Communication Services: Roles and General Responsibilities of Speech-Language Pathologists, R.1, revision date 11/19/12; ▪ CCSSLC Communication Services: Process for Servicing Individuals at High Risk (with Challenging Behaviors), R.2, revision date of 1/28/14; ▪ CCSSLC Communication Services: Assessment, R.3, revision date 1/23/14; ▪ CCSSLC Communication Services: Referral Criteria, R.4, revision date 1/28/14; ▪ CCSSLC Communication Services: Guidelines for Direct Speech Therapy/Communication Supports, R.5, implementation date 10/3/13; and ▪ CCSSLC Communication: Ordering Mobile Modified Barium Swallow Studies, R.6, implementation date 2/15/14. The Facility-based SLP/communication policies and protocols did include the following: ▪ Roles and responsibilities of the SLPs (meeting attendance, staff training etc.); ▪ Outline of the assessment schedule; ▪ Frequency of assessments/updates; ▪ Timelines for completion of new admission assessments (within 30 days of admission or readmission); ▪ Timelines for completion of comprehensive assessments (within 30 days of identification of need via screening); ▪ Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT); ▪ A process for effectiveness monitoring by the SLP;	

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		▪ Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment; ▪ Methods of tracking progress and documentation standards related to intervention plans; and ▪ Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as problem resolution. The essential components of a monitoring policy are addressed with regard to Section R.4. In summary, the Facility had established a caseload methodology that memorialized the process for determining SLP caseloads. The Facility employed an adequate number of SLPs with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. The SLPs were licensed to practice in the state of Texas and provided evidence of current ASHA certification. SLPs had completed continuing education directly related to communication and transferrable to the population served. The Facility SLP policies and protocols included necessary components as discussed within this section. The Facility was in substantial compliance with this provision.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**Communication Assessments Provided for Individuals Newly Admitted to CCSSLC** The CCSSLC Communication Services: Assessment, Policy R.3, indicated: "a screening tool may be completed if the Speech-Language Pathologist determines it is the most appropriate tool, when: a new admission is received (within 30 days); as a diagnostic tool to guide clinicians in formulating a full evaluation, and as evidence in determining absence or presence of risk in specific areas." Three of three (100%) newly admitted individuals (i.e., Individual #35, Individual #45, and Individual #78) received a communication screening and/or assessment within 30 days of admission or readmission. Two of these individuals (i.e., Individual #45 and Individual #78) received a SLP assessment. Individual #35's screening results did not recommend a SLP assessment. **Communication Assessment** The Facility continued to have a reasonable plan to assess individuals who would benefit from the use of alternative or augmentative communication systems. The Facility had defined the timeframe for the completion of communication assessments for individuals. Specifically, individuals' Communication Comprehensive Assessments had been completed by 11/1/12. There was no waiting list for completion of SLP assessments. Based on policy, Assessments of Current Status were being completed prior to the	Substantial Compliance

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		individual's annual ISP meeting. The ten SLP assessments reviewed for the individuals in Sample R.1 were current within the last 12 months. Based on review of the individuals in Sample R.1, the following provides the details of the comprehensiveness of the communication assessments: ▪ Ten of 10 individuals' speech and language assessments (100%) were signed and dated by the clinician upon completion of the written report; ▪ Ten of 10 individuals' SL assessments (100%) were dated as completed at least 10 working days prior to the annual ISP; ▪ Ten of 10 individuals' SL assessments (100%) included diagnoses and relevance of impact on communication; ▪ Ten of 10 individuals' SL assessments (100%) included individual preferences, strengths, and needs. Preferences listed were derived from the Preferences and Strengths Inventory (or other relevant document) developed by the individual's team, as well as information obtained from staff interviews. However, as discussed with regard to Section F, assessors were not yet fully incorporating individuals' preferences and strengths into recommendations or proposed programs; ▪ Ten of 10 individuals' SL assessments (100%) included medical history and relevance to communication. The medical history refers to medical conditions that would impact the provision of SLP communication supports and services; ▪ Ten of 10 individuals' SL assessments (100%) listed medications and discussed side effects relevant to communication; ▪ Ten of 10 individuals' SL assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels. ▪ Ten of 10 individuals' SL assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Ten of 10 individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); ▪ Ten of 10 individuals' SL assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally; ▪ Ten of 10 individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities. The SLP assessment discussed how an individual's current abilities could be enhanced; ▪ Ten of 10 individuals' SL assessments (100%) provided a discussion of the	

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		individuals' potential to develop new communication skills. The SLP assessment provided an analysis of the individual's current communication deficits with suggestions for SAP writers and IDT members for direct interventions and/or skill acquisition programs; ▪ Ten of 10 individuals' SL assessments (100%) included the effectiveness of current supports, including monitoring findings. However, as discussed with regard to Sections R.3 and R.4, this was limited, because the Facility did not yet have a fully functioning system to monitor the provision or effectiveness of supports (i.e., monthly notes that evaluated progress based on data); ▪ Ten of the 10 individuals' SL assessments (100%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC; ▪ Ten of 10 individuals' SL assessments (100%) offered a comparative analysis of health and functional status from the previous year. For these individuals, the SLP assessment provided an overview of an individual's health status over the past year. The therapist discussed the type of supports and services that had been implemented to minimize the impact on the individual's functional status; ▪ Ten of 10 individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments. For these individuals, the SLP assessment provided an overview of the past assessment results with the current assessment data for communication function. The assessment analysis discussed if the individual's communication performance had remained the same, had improved, and/or had regressed; ▪ Ten of 10 individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it; ▪ Ten of 10 individuals' SL assessments (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Ten of 10 individuals' SL assessments (100%) had a reassessment schedule; ▪ Ten of 10 individuals' SL assessments (100%) supplied a monitoring schedule; ▪ Ten of 10 individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. For these individuals, the SLP assessment analysis section provided clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs; ▪ Ten of 10 individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition; and ▪ Ten of the 10 individuals' SL assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. The SLP assessments provided suggestions for direct support professionals and other IDT members, as appropriate, to implement an individual's indirect	

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		programs (i.e., PNMP) and reinforce skills being learned in direct therapy interventions. Twenty-three of the 23 SLP assessment elements (100%) were present in each of the ten assessment reviewed. **<u>SLP and Psychology/Behavioral Health Services Specialists Collaboration</u>** The CCSSLC Communication Services: Monitoring Process for Individuals at High Risk (with Challenging Behaviors), Policy R.2, memorialized the following SLP responsibilities in achieving collaboration with Psychologists/Behavioral Health Specialists: ▪ "When reviewing data/information to develop a Comprehensive Assessment or Assessment of Current Status, the most recent Positive Behavior Support Plan (PBSP) will be reviewed. The replacement behavior will be determined and analyzed for integration with overall communication needs; and ▪ The psychologist that produced the PBSP will be contacted for collaboration of needs/results." Based on a review of seven individuals in Sample R.3 with Positive Behavior Support Plans the following was noted: ▪ Seven of seven individuals' communication assessments and PBSPs (100%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ Seven of seven individuals' communication assessments (100%) contained evidence of review of the PBSP by the SLP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 8/7/13 to 1/29/14, participation by a SLP was noted in 17 of the 19 meetings (89%). In summary, individuals who had been newly admitted to CCSSLC had a SLP screening and/or assessment completed within 30 days, SLP/communication assessments included necessary components, and SLPs and Psychologists/Behavioral Health Specialists were collaborating in the development of individual-specific communication strategies for behavioral support/interventions. The Facility remained in substantial compliance with this provision.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication	**<u>Integration of Communication in the ISP</u>** Based on a review of the ISPs for nine individuals in Sample R.4, the following was noted: ▪ Three of nine individuals' SLP (33%) (i.e., Individual #147, Individual #268, and Individual #58) attended the annual ISP meeting. ▪ Three of nine individuals ISPs (33%) (i.e., Individual #136, Individual #298, and Individual #305) included a description of how the individual communicated	Noncompliance

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	systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	and how staff should communicate with the individual, including the AAC system if he/she had one. The missing component for the six remaining individuals was a description of how staff were to support functional communication with the individual's AAC system. ▪ Communication Dictionaries for three of six individuals (50%) (i.e., Individual #136, Individual #58, Individual #305) were reviewed at least annually by the IDT as evidenced in the ISP and/or ISPA. Three individuals did not have a Communication Dictionary (i.e., Individual #147, Individual #268, and Individual #298). ▪ None of nine ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. ISPs should contain information on how communication strategies can be integrated throughout the day and throughout the other selected goals. Information should be consistent with the communication assessment and provide detailed descriptions to ensure staff consistency. ▪ Four of nine ISPs reviewed (44%) (i.e., Individual #137, Individual #268, Individual #136, and Individual #305) contained skill acquisition programs to promote functional communication. As appropriate to the individual's needs, ISPs should contain a program (direct or indirect) that is aimed at improving functional communication. Individuals with AAC systems should have skill acquisition programs and/or other specific staff supports to promote the generalization of the use of the AAC system in multiple environments. ▪ None of nine ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. The ISPs should provide information on status of goals/programs and recommendations for the future. This information should include data as appropriate. **Development and Implementation of Functional Individual-Specific Assistive Communication Systems** The Monitoring Team and Facility SLPs conducted observations in the homes and/or day programs of seven individuals (i.e., Individual #298, Individual #367, Individual #91, Individual #136, Individual #137, Individual #147, and Individual #145). ▪ Seven of seven observations (100%) found individuals' AAC devices present in each observed setting and readily available to the individual. ▪ AAC systems for seven of seven individuals (100%) were noted to be in use in each observed setting. ▪ AAC systems for seven of seven individuals (100%) were portable. ▪ AAC systems for seven of seven individuals (100%) were functional. ▪ For seven of seven individuals (100%), staff instructions/skill acquisition plans related to the AAC system were available.	

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		General Use AAC Devices The Facility maintained a List of General Common Area Devices, revised 2/14/14. The list identified the location, type and intent of the device, and the date verified. During the review, the Monitoring Team and Facility SLPs and a SLPA observed the presence of general-use AAC devices including staff instructions during observations of individuals in their residences and workshops. **Direct Communication Interventions** At the time of the review, 10 individuals were receiving direct speech therapy. Sample R.2 included five of these 10 individuals. A review of these individuals' records found the following: ▪ Two of five individuals' direct intervention plans (40%) (i.e., Individual #40 and Individual #268) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For four of five individuals' records reviewed (80%) (i.e., Individual #147, Individual #137, Individual #40 and Individual #268), the current SLP assessment identified the need for direct intervention with rationale. ▪ For one of five individuals' records reviewed (20%) (i.e., Individual #137), there were measurable objectives related to individual functional communication outcomes included in the ISP. ▪ For none of five individuals (0%), information was present regarding whether the individual showed progress with the stated goal on a monthly basis. The monthly notes for these three individuals did not provide a summary of data to show objectively whether or not the individuals made progress on the specific objectives included in their programs, and, if not, what the causes might have been. ▪ For none of five individuals (0%), a description was found of the benefit of the device and/or goal to the individual. ▪ For none of five individuals (0%), a report was found regarding the consistency of implementation. ▪ For none of five individuals (0%) recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. Based on the therapist's monthly data, if a lack of progress is noted, team review would be necessary to determine if the plan is being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the SLP, in collaboration with other IDT members, should revise these interventions. ▪ For none of one individual's records (0%) reviewed (i.e., Individual #268), termination of intervention was well justified and clearly documented in a timely manner. The four remaining individuals' direct SLP therapy had not been	

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		terminated, nor had they been discharged from therapy (i.e., Individual #147, Individual #137, Individual #40 and Individual #136). **Competency-Based Training and Performance Check-offs** Competency-based training and performance check-offs for communication are addressed with regard to Section O.5 for new employees and veteran staff. **Individual-Specific Competency-Based Training** Nine of the nine individuals' staff in Sample R.4 had received individual-specific training. However, the training documentation presented was not adequate to ascertain if all required staff had completed competency-based training and performance check-offs for these individuals' AAC devices. The Monitoring Team requested individual-specific training documentation to identify the total number of staff (N) required to complete the training and the total number of staff (n) that had successfully completed individual-specific competency-based training and performance check-offs. The Facility reported database entries from individual-specific training for functional communication for the past six months continued to be a work in progress. To substantiate compliance with the provision of individual-specific training, the Facility will have to produce this training data. In summary, observations of individuals with AAC devices showed individuals had their equipment and were using it, with staff assistance as necessary. ISPs generally provided some description of individuals' communication skills, but a description of how staff were to engage individuals with their AAC systems was not present. More work was needed to incorporate communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress. For individuals receiving direct therapy, two of the five individuals' plans were implemented in 30 days. Most of the SLP assessments provided a rationale for direct therapy. Additional work with monthly progress notes will need to be done for individuals receiving direct therapy interventions. Speech Therapy Monthly Progress Reports for individuals provided a note for each individual session. However, there was not a sufficient monthly summary note (i.e., information regarding whether the individual showed progress with the stated goal on a monthly basis, and a description of the benefit of the device and/or goal to the individual). Individual-specific training and performance check-offs had been developed and implemented for some of the individuals in the sample. However, it could not be determined if all the required staff had successfully completed the competency-based training and performance check-offs. The Facility remained out of compliance with this section.	

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R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**Monitoring System** The Facility's policies/procedures did include the following elements related to monitoring (i.e., CCSSLC Communication Supports Guidelines: Monitoring): ▪ Monitoring for the presence of communication adaptive equipment or other AAC supports/materials; ▪ Monitoring for the working condition of communication adaptive equipment; ▪ Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work); ▪ The frequency of monitoring for individuals within the established Master Communication Plan priority levels; ▪ The process for identification, training, and validation for monitors; ▪ The process of establishing inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). **Monitoring of Implementation of Communication Supports** The Facility used two monitoring forms for communication: ▪ Monthly Person-Specific PNMP Check Sheet, revised on 5/8/13; and ▪ Communication Monitoring form, which was a new monitoring form and was implemented on 6/24/13. Both of these forms had adequate written instructions. Six SLPs and two Speech Language Assistants used the Communication Monitoring form. This form monitored an individual's AAC system for presence, working order, in proper placement/location per instructions, presence of communication instructions, staff was able to operate the device, the device was in use, and the condition of the device. Additional monitoring included social interaction and strategies for implementation. Twelve PNMP Coordinators completed the Monthly Person-Specific PNMP Check Sheet. Monthly Person-Specific PNMP Check Sheet and Communication Monitoring forms were reviewed for individuals in Sample R.4 and the following was found: ▪ The Monitoring Team requested six months of monitoring documentation of AAC equipment (i.e., Monthly Person-Specific PNMP Check Sheet). Two of the nine individuals with AAC systems (i.e., Individual #58 and Individual #367) (22%) had been monitored according to the frequency defined in Facility policy. For the remaining seven individuals, the Monthly Person-Specific PNMP Check Sheet had not been implemented on a monthly basis as defined in Facility policy and/or their AAC devices were not identified on the monitoring form.	Noncompliance

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		▪ Communication Monitoring forms were requested for three months. Seven of the eight individuals' staff (88%) (i.e., Individual #136, Individual #137, Individual #147, Individual #305, Individual #367, Individual #268, and Individual #298) had been monitored at the frequency defined in policy. Individual #58's communication monitoring had been suspended due to frequent changes in communication programs and supports. The Communication Monitoring forms identified multiple areas of staff noncompliance with individuals' AAC devices. The Facility reported the process for data trend analysis of monitoring results was addressed in SLP Case Study meetings that occurred three times per month. Issues were discussed, problems solved, and solutions determined. The SLP Lead reported there was a better partnership between Residential Staff and SLPs as a result of the monitoring, including required mentoring and training when issues were identified. The meeting minutes identified multiple individuals' monitoring results and discussed strategies to resolve identified issues. The data trend analysis of communication monitoring results should expand beyond SLP Case Study meetings to the QA/QI Council. Monitoring data should be analyzed and presented to the QA/QI Council. In summary, the Facility had policies/procedures that incorporated the elements necessary for monitoring communication supports. Individuals with AAC systems had not been monitored on a consistent basis using the Monthly Person-Specific PNMP Check Sheet. Since the last review, the completion of Communication Monitoring had significantly improved. However, a review of individual-specific monitoring forms indicated multiple areas of staff noncompliance. The monitoring data should be analyzed, trended, and reported to the QA/QI Council to develop more systemic resolution strategies. The Facility Self-Assessment stated: "this provision is not in compliance but is improving greatly." The Monitoring Team agrees with this statement. The Facility remained out of compliance with this subsection.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation at entrance meeting, on 3/31/14 o Section S Presentation Book; o Self-Assessment for Section S, dated 3/14/14; o Completed Section S Monitoring Tools for: Individual #79, Individual #235, Individual #3, Individual #27, Individual #28, and Individual #187; o Individual Support Plan for: Individual #297, Individual #58, Individual #298, Individual #296, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #333, Individual #237, Individual #359, Individual #77, Individual #191, and Individual #141; o Integrated Risk Rating Form and Integrated Health Care Plan for: Individual #297, Individual #58, Individual #298, Individual #296, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #333, Individual #237, Individual #359, Individual #77, Individual #191, and Individual #141; o Decision Tree for Dental Desensitization; o Skill Acquisition Plans for: Individual #297 (prepare medications/adjust water temperature), Individual #58 (make a choice/sensory skills), Individual #298 (bus route/identification of low cholesterol foods), Individual #296 (count magazines/phone calls), Individual #9 (apply sunscreen/ride in van), Individual #159 (sanitizing skills/improved participation), Individual #310 (point to destination/shredding), Individual #307 (community awareness/dry self), Individual #146 (counting skills/exercise), Individual #292 (community awareness/privacy), Individual #333 (brush hair/choice making), Individual #237 (vocational skills/time knowledge), Individual #359 (relieve anger/animal care), Individual #77 (community awareness/remote control use), Individual #191 (recognize effects of aggressive behavior/keyboard use), and Individual #141 (seatbelt use/sanitizing skills); o Summary of Integrity Checklists for Skill Acquisition Plans, from 8/13 to 1/14; o Skill Acquisition Review Committee meeting minutes, from 8/20/13 to 1/28/14; o Facility Engagement Report, from 8/13 to 1/14; o List of Individuals With Visual Impairment; o Program Review Committee Integrated Monthly Review Rubric; o Preferences and Skills Inventory for: Individual #297, Individual #58, Individual #298, Individual #296, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #333, Individual #237, Individual #359, Individual #77, Individual #191, and Individual #141; o Functional Skills Assessment Summary for: Individual #297, Individual #58, Individual #298, Individual #296, Individual #159, Individual #310, Individual #146, Individual

	#359, Individual #77, Individual #191, and Individual #141; o Functional Skills Assessment Recommendations for: Individual #9, Individual #307, Individual #292, Individual #333, and Individual #237; o Vocational Assessment for: Individual #297, Individual #58, Individual #298, Individual #296, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #333, Individual #237, Individual #359, Individual #77, Individual #191, and Individual #141; o Day Program Assessment for: Individual #78 and Individual #448; o Situational Assessments for: Individual #285, Individual #184, Individual #186, Individual #172, Individual #292, Individual #300, Individual #111, Individual #269, and Individual #91; o Individuals Employed On and Off Campus, from 8/1/13 to 1/31/14; o Education and Training Assessment for: Individual #58, Individual #296, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #333, Individual #237, Individual #359, Individual #77, Individual #191, and Individual #141; o CCSSLC Assessment Review Committee template; o Assessment Review Committee meeting minutes, for 1/22/14 and 1/31/14; o Description/listing of on-campus and off-campus day and work programs; o List of individuals who attend each day/vocational site; o Individuals Employed On and Off Campus, from 8/1/13 to 1/31/14; o Monthly Reviews or Integrated Monthly Reviews (10/13 to 12/13) for: Individual #297, Individual #298, Individual #296, Individual #159, Individual #310, Individual #292, Individual #237, Individual #359, and Individual #77; o Integrated Monthly Reviews (11/13 to 1/14) for: Individual #58, Individual #307, Individual #146, and Individual #141; o Integrated Monthly Reviews (12/13 to 2/14) for: Individual #9 and Individual #191; o Integrated Monthly Reviews (1/14 to 2/14) for: Individual #333; and o Six-month summary of community outings per residence. ▪ **Interviews with**: o Rachel Martinez, QIDP Coordinator, and Kimberly Benedict-Rodriquez, Director of Education and Training Services, on 4/1/14; o Lucy Tijerina, Vocational Coordinator, on 4/3/14; and o Mark Cazalas, Director, and Brandon Riggins, Assistant Director of Programs, on 4/3/14. ▪ **Observations of**: o Infirmary, Dolphin Residence, Ribbonfish Apartment 524-A, Ribbonfish Apartment 524-B, Ribbonfish Apartment 524-C, Ribbonfish Apartment 524-D, Coral Sea Horse Residence, Coral Sea Sand Dollar Residence, Kingfish Apartment 522-A, Kingfish Apartment 522-B, Kingfish Apartment 522-C, and Kingfish Apartment 522-D; o Gymnasium; o Computer Center; o Kaleidoscope, Comfort Zone, Outer Reef Hurricane Alley, Vocational Annex, Vocational

	Building, Sailfish Vocational Program; o Restraint Reduction Committee meeting, on 3/31/14; o Restrictive Practices Committee meeting, on 3/31/14; o Skill Acquisition Review Committee meeting, on 4/1/14; o Programming Review Committee meeting, on 4/1/14; o Internal Peer Review meeting, on 4/2/14; o Self-Advocates meeting, on 4/3/14; and o Behavior Support Committee, 4/3/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S, dated 3/14/14. In its Self-Assessment, for each sub-section, the Facility had identified: a) activities engaged in to conduct the self-assessment; b) the results of the self-assessment; and c) a self-rating. For Section S, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring templates and guidelines, and a sample of completed monitoring tools: o The monitoring tools the Facility used to conduct its self-assessment included the Section S – Habilitation, Training, Education, and Skill Acquisition Program Tool Guidelines; the Section F and Section S Monitoring Tool; and Individual Support Plan Meeting and Document Checklist/Habilitation, Training, Education, and Skill Acquisition Program Checklist; and Skill Acquisition Program Rubric. o These monitoring tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as a review of documents. o The Self-Assessment identified the sample(s) sizes. o Inter-rater reliability had been completed on several of the samples provided to the Monitoring Team. However, the data from these inter-rater reliability checks were not reported in the Self-Assessment. ▪ The Facility used other relevant data sources. o The Self-Assessment also contained data from other relevant sources. This included data obtained from sampled skill acquisition plan rubrics, engagement tools, integrity checklists, and integrated monthly reviews. In addition, data was obtained from the review of sampled assessments, including educational and training assessments, functional skills assessments, preference and strengths inventories, vocational assessments, and situational assessments. Lastly, data regarding attendance at work and day program sites and participation in community outings was utilized as well. ▪ The Facility consistently presented data in a meaningful way. ▪ The Facility rated itself as being out of compliance with the three sub-sections of Section S. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The Facility was providing on-going review of the quality of habilitation assessments through its Assessment Review Committee. Ongoing feedback also was provided

	on the quality of skill training programs through the Skill Acquisition Review Committee. Both of these committees included interdisciplinary members who provided comprehensive and thoughtful feedback during document review. Integrated Monthly Reviews provided a cumulative review of progress to allow for timely revision of programs as necessary. The Facility was also making good efforts to expand the variety of programming available to individuals, particularly in the area of vocational services. A greater number of individuals were leaving their homes to participate in day programs for some portion of the week. On campus shuttle bus service had improved individuals' abilities to get to and from their scheduled activities. Staff schedules also had been varied to expand active treatment and supports to evening hours and weekends. Although the Facility had in place many very positive strategies to ensure adequate habilitation and educational services to the individuals served, the Facility remained out of compliance with all subsections of Section S. For example, although improvement was noted, problems continued to exist with skill acquisition programs (SAPs), such as the absence of behavioral objectives, limited teaching trials, and teaching conditions that did not provide clear and comprehensive instructions. Engagement continued to be low in residences and classrooms and day programs. Assessments such as Preference and Strength Inventories and Functional Skills Assessments continued to lack necessary information and/or summary/analysis, and as a result were of limited usefulness to teams responsible for developing habilitation plans for individuals. Community training opportunities continued to be limited.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	The most recent Individual Support Plan was reviewed for 16 individuals. ISP meetings were held between 6/6/13 and 2/12/14. A summary of findings is provided below. ▪ All of the ISPs (100%) included a brief review of the individual's preferences and strengths. ▪ A total of 78 training objectives were identified in the 16 ISPs, with a range of three to eight objectives per individual. This calculated to an average of 4.9 Skill Acquisition Plans (SAPs) per individual. o The identified training schedule was as follows: 38 SAPs (49%) to be trained daily; 14 SAPs (18%) to be trained once per week; six SAPs (8%) to be trained five days each week; five SAPs (6%) to be trained once per month; and two SAPs each to be trained twice per week, three times per week, or once each month/quarter. The four SAPs for Individual #9 suggested training should occur "as scheduled," and the five SAPs for Individual #237 had no schedule identified. Training was identified as occurring multiple times in one day on only three SAPs (i.e., Individual #310 and Individual #333). Regrettably one of these two SAPs for Individual #310 referenced staff behavior rather than the individual's behavior. Dense schedules of training are recommended to	Noncompliance

		ensure skill acquisition. o The community was identified as a possible training environment for 20 of the 78 SAPs (26%). The community was identified as a possible setting for all four of the SAPs for Individual #9, yet his ISP indicated that he did not like to travel off campus. Similarly, the community was identified as a possible training site for all five of the SAPs for Individual #359, yet some clearly indicated that training would need to occur on campus (e.g., cooking classes). o The conditions under which the training was to occur were identified in none of the 78 (0%). Broad acquisition criteria were identified in 39 of the 78 objectives (50%). In 32 of these 39 objectives (82%), criteria were identified as the individual's demonstration of designated steps in a task analysis. The specific steps were not identified. o Of the 67 objectives included in the 14 ISPs, 34 (51%) matched recommended SAPs identified in the individual's Functional Skills Assessment . (It should be noted that the 11 SAPs identified in the ISPs for Individual #191 and Individual #141 were excluded from this analysis, because the FSAs provided for review were incomplete.) Assessments are only useful if they are considered when designing habilitation plans. The IRRF and the IHCP were reviewed for the 16 individuals in the sample. Particular attention was paid to dental health ratings. A summary of findings is provided below. ▪ Eleven of the 16 individuals in the sample were identified as requiring pre-treatment sedation for dental work. Dental was identified as a medium risk for eight of these 11 individuals (i.e., Individual #58, Individual #298, Individual #159, Individual #310, Individual #307, Individual #333, Individual #77, and Individual #141), a high risk for two individuals (i.e., Individual #296 and Individual #146), and a low risk for one individual (i.e., Individual #9). As the SSLC Risk Guidelines, dated 6/18/12, indicated that use of general anesthesia or TIVA for dental care should reflect a high risk rating, teams should review the risk ratings for the eight individuals with a medium risk rating as TIVA was utilized or recommended for dental procedures. Further, staff should check the correspondence between documents, because Individual #292 had a high dental risk rating in his ISP, but a low dental risk rating in his IRRF. ▪ Team approval for pre-treatment sedation was noted in the rights restriction section of the ISP for eight of the 11 individuals (73%). The exceptions were Individual #298, Individual #296, and Individual #159. Teams should ensure regular review and informed consent by the team whenever pre-treatment sedation is utilized. ▪ As noted in the IRRF, 10 of the 11 individuals (91%) had been referred to Behavioral Health Services for evaluation for a desensitization plan. The	

		exception was Individual #298. Four of these 10 individuals (40%) had been deemed to be not appropriate candidates for desensitization. While individual-specific information was not included to support this determination, the Facility did provide a Decision Tree for Dental Desensitization that was used when considering the individual's appropriateness for a plan. Two Skill Acquisition Plans for each of the 16 individuals in the sample were reviewed. A summary of the review of these 32 SAPs is provided below. ▪ In one of the 32 SAPs (3%), a behavioral objective was identified. The SAP for Individual #310 in which he was to identify a community destination of his choice included the conditions under which the behavior was to occur, an observable and measureable response, and mastery criteria. Many of the remaining objectives either did not identify the conditions under which the behavior was to occur or the observable and measureable behavior the individual was to demonstrate. It should be noted that the SAPs did include an operational definition section that occasionally described the behavior in observable and measureable terms. ▪ All of the 32 objectives (100%) included mastery criteria identified as a number of specified assessment trials over a specified number of months. ▪ Twenty-nine of the 32 SAPs (91%) had been identified in the individual's ISP. The exceptions were the two SAPs reviewed for Individual #237, and the food identification program for Individual #298. While these SAPs might have been appropriate skills to teach, it is important that plans are written to address all of the skills requiring training that are identified at the individual's annual meeting. ▪ Where appropriate, a task analysis was identified in 18 of 18 SAPs (100%). The task analysis for seatbelt use for Individual #141 might have been strengthened with additional steps (e.g., will grasp seatbelt, will pull seatbelt across waist, etc.). ▪ All of the 32 SAPs (100%) indicated that forward chaining was to be utilized when teaching the skill. However, in 14 of the SAPs (44%), the skill was not a behavioral chain, but rather a discrete skill or a skill that was to be shaped over time. Examples included pointing to a picture or looking at an item, and sitting in a van or participating in an activity for gradually increased periods of time. Staff should ensure that teaching techniques are clearly and appropriately identified. ▪ Where necessary, materials were adequately identified in 27 of 28 SAPs (96%). The exception was the SAP for Individual #146, because her exercise DVD was not listed. ▪ The schedule for training varied widely across SAPs. Training was scheduled to occur daily in 14 SAPs (44%), three times per week in two SAPs (6%), once per week in nine SAPs (28%), twice per month in one SAP (3%), and once per month in six SAPs (19%). Only two of the 32 SAPs (6%) identified more than one daily	

		trial, because training was to occur before or during medication administration. To ensure timely progress, it is important to provide sufficient opportunities for individuals to learn new skills. ▪ Eleven of the 32 SAPs (34%) clearly identified the community as a training site. What was interesting was that seven of these 11 SAPs identified the campus as the generalization site once the skill was mastered. As more frequent learning opportunities could occur on campus, it is suggested that training occur in both environments concurrently. This might foster more rapid skill acquisition. ▪ In 15 of the 32 SAPs (47%), praise and some other form of positive feedback (e.g., a pat on the back) was the identified reinforcer for correct responding. Caution is advised, because praise and other forms of positive feedback do not always function as a reinforcer. It might be dependent upon the relationship the individual has with the person delivering the praise, or it might not be sufficiently motivating for the individual to learn a new and possibly difficult skill. The remaining 17 SAPs indicated praise and some tangible reinforcer (e.g., an item, an activity) be provided contingent upon correct responding. ▪ All of the SAPs (100%) provided guidelines to follow when the individual did not respond correctly. These consistently noted that another trial should be attempted with staff following the prompting sequence. All of the plans noted a least to most prompting sequence. There are times when a least-to-most prompting sequence might not be the most appropriate. For example, Individual #141 was learning to use a seatbelt. The SAP noted that a trial was correct if full physical assistance was provided. This is an example of a skill where increased independence could be taught if teaching began with the most intrusive prompt (i.e., full physical assistance) and then was faded over time as the individual learned the steps in the sequence. It is also important to consider a specific hierarchy of prompts when teaching any skill. Prompting strategies should be specific to the skill. For example, not all skills, including verbal communication, are amenable to physical prompting. As such, a full physical prompt should be excluded from the prompting hierarchy in these SAPs. ▪ Although the SAP format included a section identified as teaching conditions/schedule, these did not provide clear and comprehensive instructions for conducting a teaching trial. Most of the plans provided a review of communication strategies that, while important, were not specific to the identified skill. Others indicated the location of training, but did not clarify how stimuli were to be presented. The one exception was the plan for Individual #9 that fairly simply and clearly identified how to teach him to apply sunscreen. Individual specific suggestions and concerns are noted below: o Several plans included discriminative stimuli that were not appropriate to the activity/skill. For example, staff were to present Individual #58 with a lotion bottle in his sensory program. It is suggested that they should have used a verbal stimulus to let him know what was to occur.	

		While it was clear that there was an effort made to use natural discriminative stimuli, there are many teaching programs in which a verbal instruction from the trainer is most appropriate. o The discriminative stimulus in one SAP for Individual #191 consisted of the staff inviting the individual to discuss safe behaviors in the community. However, the task analysis involved his defining assault and its consequences. o Individual #298 was to learn to identify foods low in cholesterol, but nowhere in the plan was there a list of possible foods. Similarly, Individual #359 was to learn ways to relieve his anger, but the plan did not provide a list of appropriate strategies for him to use. o Individual #9 was to learn to sit in a van without protest, but the program might be enhanced if he could listen to music, hold a preferred item, or be engaged in some other way during this passive event. ▪ All of the 32 SAPs (100%) included plans for maintenance and generalization. Each plan identified a specific number of probes on which maintenance and generalization of the skill was to be assessed within 30 days of mastery. This was a very positive component of the plans. One suggestion would be to clearly identify criteria to determine that maintenance and/or generalization had occurred. ▪ All of the 32 SAPs (100%) included the individual's ISP date and the date of plan implementation. ▪ Staff should carefully proof all SAPs. Several plans included the names of other individuals, suggested reinforcers that were not appropriate to the individual (e.g., a thumbs up gesture for an individual who was visually impaired, access to television or time on the patio for an individual who was learning a community-based skill), or noted activities that differed from the targeted skill. In sum, these SAPs contained some very good information. Staff should carefully review all teaching conditions/methodologies to ensure that discrete events, shaping programs, and/or behavioral chains are appropriately identified with clear teaching instructions for staff to follow. Consideration should also be given to utilizing a most-to-least prompting hierarchy when appropriate. It was noteworthy that the Facility was conducting regularly scheduled integrity checks on skill training programs. Active Treatment Coordinators were expected to conduct two integrity checks each week in each home. Beginning in 1/14, inter-rater reliability checks were conducted once per week with the Program Coordinator. This was a most commendable practice. A review also was completed of the minutes from 17 meetings of the Skill Acquisition Review Committee held between 8/20/13 and 1/28/14. Staff participating in these meetings were as follows: Director of Education and Training (94%), one to four Active	

		Treatment Coordinators (100%), Speech and Language Pathologist (94%), Board Certified Behavior Analyst (71%), QIDP Coordinator (53%), Behavioral Health Specialist (12%), Program Compliance Monitor (12%), and Lead Instructor (6%). Minutes reflected detailed feedback on specific SAPs. This was also apparent at the meeting the Monitoring Team attended during the week of the review. One suggestion would be to invite one or more direct support professionals who work with the individual whose program is under review. With 40 individuals identified as having a severe visual impairment and 34 individuals identified as having a moderate visual impairment, the Facility should engage an Orientation and Mobility Specialist to provide consultation services. Specialized teaching strategies should be included in all SAPs for these identified individuals. <u>Engagement</u> During this visit, PLACHECKS or measures of engagement, were collected in the homes, vocational settings, and day programs. A total of 22 PLACHECKS were collected in the homes. Measures ranged from 0% to 100%, with a mean of 18.72% engagement. It should be noted that a visit to the Coral Sea Unit in the late afternoon revealed most residents in small groups in front of a television, listening to music, or involved with an active treatment staff member. In each observation, the majority of the individuals were asleep or otherwise unengaged. The ability to engage these individuals might be difficult due to their health and medical needs. Although engagement scores were low, it was encouraging to learn of the ongoing efforts to provide some level of participation in day programs outside of the home environment. A total of seven PLACHECKS were conducted in the vocational settings. Measures ranged from 67% to 100%, with a mean of 81% engagement. Although most individuals were engaged in the preparation of paper for shredding or actual shredding of paper, others were observed working on more individualized programs. One individual was stocking supplies, others were preparing cardboard for recycling or hangers for reuse, and a small number of individuals were creating wood products for future sale. In the classrooms or day programs, 11 PLACHECKS were collected. Engagement ranged from 0% to 80%, with a mean of 40.5% engagement. Observed activities included painting or creating collages, watching movies, completing math worksheets, enjoying snacks, listening to music, or completing self-care routines. Staff should consider the appropriate context for all activities. While the development of self-care skills is an important focus of all training, one individual was observed practicing tooth brushing skills while seated at a table with a group of individuals. This particular skill should be practiced in the bathroom and not in a group living environment. The Facility is commended for the variety of programs available in both the day program sites and the vocational settings. It is also noteworthy that an on-campus shuttle service had been introduced to assist individuals as they transitioned to and from day	

		activities. The Facility provided a copy of the Facility Engagement Report from 8/13 through 1/14. This report reflected between three and 53 engagement checks per month across all home units and day program sites. The Facility is commended for their frequent assessment of engagement and for developing action plans when engagement was below 75%. As described by the Director of Education and Training, the scores might have been inflated due to the tool in use. Staff were directed to observe individuals and score engagement if this was observed at any moment within the five-minute observation interval. Staff should review the literature for different measures of engagement. PLACHECKS typically involve a momentary time sample in which each individual is observed for a brief (e.g., 10 seconds) period of time. The Facility had clearly taken steps to improve the habilitation services provided to the individuals served. Continued improvement in the areas noted above will be necessary to achieve substantial compliance in this provision of the Settlement Agreement.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	Prior to the ISP meeting, the team was expected to complete the Preferences and Strengths Inventory for the individual. The first part of this form required the team to record responses to a range of questions related to living options, employment activities, relationships, leisure skills, and independence. The team also was expected to record the method used to identify the individual's preferences. The second section required the team to summarize the individual's preferences and strengths. The final analysis section posed questions to help develop goals to meet the individual's preferences for future living options, employment, relationships, leisure skills, and independence. The PSIs for the 16 individuals in the sample were requested. A summary of this review is provided below: ▪ The PSIs for 14 of the 16 individuals in the sample (88%) were completed before the most recent ISP date. The two exceptions were Individual #159 and Individual #307. The PSI for Individual #159 was signed on the same date as her ISP meeting. Although the PSI for Individual #307 was updated four times between 6/15/13 and 1/15/14, it was signed 11 months before her ISP date. ▪ All of the PSIs (100%) were signed by the individual's QIDP. ▪ Questions regarding future living options, employment, relationships, leisure skills, and independence were addressed in all of the PSIs (100%). However, the quality of the information provided varied considerably across individuals. Specific examples are provided below: o Those individuals who were verbal, such as Individual #359 and Individual #191, often had PSIs that provided a better summary of preferences. o For others, including Individual #159, Individual #237, and Individual #77, it was repeatedly noted that the individual was nonverbal, unable to answer the question, and/or displayed no response. It is suggested	Noncompliance

		that family or staff members report on what they have observed. o Family was identified as preferred by and important to Individual #310, yet it was noted that his family could not be located. It would appear that other important relationships should be identified and pursued. o When considering participation in groups, the Boy Scouts were a consideration for Individual #310, although he was 46 years old at the time of his ISP meeting. When staff were asked to consider Individual #307 joining a group, it was noted that the concept of group had no meaning for her. However, earlier in the PSI, it was noted that she was very social. It would appear that a group that focused on a preferred activity might be enjoyable for this individual. o When the team was asked to describe the place Individual #292 would want to live, the question was identified as not applicable. It is suggested that there must be some observation of preferred environments for this individual. ▪ Brief summaries of preferences and strengths were provided for all 16 individuals. Staff should provide a comprehensive summary of preferences and strengths to help guide future programming. Staff also should avoid generalizations about an individual based upon his/her diagnosis. For example, a diagnosis of autism was referenced in the PSI for Individual #237. It was suggested that his "activities seem to be more dictated by his autism than by personal preferences." This statement mistakenly suggests that all individuals with a particular diagnosis share identical preferences and characteristics. ▪ The final section, which guides teams to consider future planning for the individual, was completed for all 16 individuals (100%). However, the information was very brief and often did not identify plans beyond the individual's current environments or activities. Individual specific examples are provided below: o Individual #297, Individual #58, and Individual #9 were all to continue with their current programming. o A statement in the PSI for Individual #237 noted: "As (he) is autistic and internally driven it is difficult to assess his progress." This diagnosis does not preclude an objective assessment of progress. o The PSI for Individual #359 noted that he would be interested in living in a group home, although he had clearly stated that he did not like group homes. It was also suggested that this individual would like to learn to cook, although earlier in the inventory it was noted that he had cooking skills. o The summary for Individual #191 suggested that he wanted to continue with his current job, although when asked, he had responded that he did not like his current work. The team should engage in a thoughtful discussion of all areas outlined in the PSI, with	

		input from the individual and those who know him/her well, to ensure that the outcome is a comprehensive profile of the individual's preferences and strengths. This should then be used to guide future planning, with barriers to goals and accompanying action plans clearly outlined. Efforts should be made to expand opportunities beyond what is currently in place at the Facility. The Functional Skills Assessment Summary report was reviewed for the 11 individuals in the sample, and the Functional Skills Assessment Recommendations report was reviewed for five individuals in the sample. Two of these reports were deleted from the analysis, because the Facility had provided only odd numbered pages (i.e., Individual #191 and Individual #141). A summary of findings for the remaining 14 reports is provided below: ▪ In every report (100%), the assessment had been completed before the individual's ISP date. ▪ All of the reports were signed (100%). ▪ In 10 of the 14 reports (71%), a statement regarding the individual's abilities, or lack thereof, was provided across all 13 domains assessed by the instrument. The reports for Individual #297, Individual #298, Individual #296, and Individual #237 had sections in which no information was provided. A summary of the individual's abilities should be provided in each area. ▪ Even in the 10 reports in which strengths were summarized, there was a good degree of variability in the information provided. Individual specific examples are provided below: o A few reports provided specific information about an individual's strengths. Examples included: ▪ Individual #58 – dressing skills; ▪ Individual #159 – dressing, communication, social, and dining skills; ▪ Individual #310 – dressing, restroom, social, dining, and leisure skills; and ▪ Individual #359 – domestic, academic skills, and telephone skills. o Reports for Individual #58, Individual #9, Individual #159, Individual #310, Individual #307, Individual #146, Individual #292, Individual #333, and Individual #77 often noted that the person had no strengths in the area assessed. While skills might be quite limited for some individuals, every attempt should be made to summarize any means the individual has to communicate, to engage in social interaction, or to cooperate with activities of daily living. This document should provide a fairly comprehensive profile of the individual's strengths and skills. o Other reports suggested "independence," "some independence," "some knowledge," "independence in most areas," or "strengths in all areas"	

		without clearly identifying the skills and strengths displayed by the individual. Future planning for comprehensive habilitation services cannot occur without a clear understanding of the person's current skills. These broad descriptions of strengths were noted in the reports for Individual #298, Individual #237, and Individual #359. ○ In some cases, there was contradictory information provided within this brief report. For example, Individual #58 was identified as having no strengths in leisure skills. Later in his report, he was reported to have strengths in this area. Similarly, the IDT for Individual #9 identified his participation in daily living skills as a strength, although the summary of his assessment suggested that he had no strengths in dressing, restroom, or hygiene/grooming skills. ▪ Areas of need were also identified across the 13 domains assessed. While the summary for Individual #359 was fairly comprehensive, most were quite limited in scope and failed to guide future habilitation planning. Typically, a level of assistance was identified for the individual to complete all areas of need. The assessment should be utilized to identify clear skills that will build on the individual's current skills and/or allow the individual to become more independent. ▪ Between two and six skill acquisition programs were recommended in the summary reports. This computed to an average of 3.6 programs per individual. With 13 skill areas assessed, consideration should be given to the development or expansion of skills in all domains identified in the FSA. This would help provide teams with options, and then the teams should prioritize skills on which to offer individuals training. The most recent Vocational Assessment was provided for the 16 individuals in the sample. A summary of the review of these documents is provided below: ▪ All of the 16 assessments (100%) were completed within the 12-month period before their annual ISP meeting. ▪ Seven of the 16 assessments (44%) were updates for individuals who were identified as having no vocational vision or no interest in working. For six of these seven individuals (i.e., Individual #9, Individual #159, Individual #307, Individual #292, Individual #333, and Individual #77), future vocational exploration would occur only at the request of the Interdisciplinary Team. Individual #141 had been assessed for a simple task she could complete from a stationery position, with consideration for employment at the gift shop on campus. It was unclear whether this opportunity had been pursued as this assessment had occurred after the date of the report. ▪ A vocational vision was identified in eight of the remaining nine assessments (89%). For three individuals (i.e., Individual #297, Individual #296, and Individual #310), their vision was to continue with their current on-campus	

		jobs. Individual #298 and Individual #191 were interested in working in the community, but the specific type of work was not identified. Individual #146 wanted to gain work skills, Individual #237 wanted to explore janitorial or busboy work, and Individual #359 wanted to continue with on-campus janitorial work in hopes of gaining competitive employment in the community. Only Individual #58 had no clear vocational vision. ▪ Situational assessments completed within the previous year, and the individual's response to the same, were reported in seven of the 16 reports (44%). For three of the seven individuals (43%), situational assessments were conducted in different settings on campus. For the other four individuals (57%), assessments were completed in a range of community-based settings, involving a variety of jobs. The Facility staff are commended for conducting assessments and tours in an effort to identify individual preferences. ▪ Clearly identified action plans for future job exploration were not included in any of the 16 reports (0%). ▪ The person completing the assessment was identified in all of the reports (100%). All of the reports (100%) were signed. Nine Situational Assessments completed between 10/13 and 3/14 were reviewed. These reports reflected situational assessments conducted both on and off campus. The individual's response to the job was recorded and further recommendations were provided. Most of the recommendations corresponded to the individual's observed or verbal response to the experience. Examples included the following: ▪ After trying a job at a local grocery store, Individual #186 voiced his dislike for the work. An alternative community-based job was recommended for future assessment. ▪ Individual #91 tried work crushing cans, but due to his poor response, it was recommended that he remain in his current job, paper shredding. ▪ Based upon his tolerance for relatively short work sessions, it was recommended that Individual #292 become involved in paper shredding for two, half-hour periods per week. Examples where the recommendations did not match the individual's response: ▪ Individual #285 was assessed for work in the arts and crafts area. Although he began to yell and bite himself when encouraged to participate, this job was recommended for him. ▪ Individual #300 enjoyed bussing tables, but then added that she did not want to work at Hurricane Alley because the individuals eating there might make her uncomfortable. However, her employment in this setting was recommended. It might be advisable to consider a different setting in which she could do similar work. The Facility provided the Monitoring Team with a report of employment activities	

		between 8/13 and 1/14. This reflected a total of 88 individuals working on campus and 15 individuals working off campus. Community-based jobs included: a) enclaves providing janitorial, lawn care, paper recycling, or sanitation work; b) competitive employment at three different sites; and c) supported employment at a local grocery store. The vocational services staff are commended for the work they have completed to create jobs that match an individual's interests and skills. Individual #59 had lost his job in the community and clearly preferred working without ongoing supervision. The staff in the Annex had developed a checklist for this man to monitor his own behavior and by all reports, he was successfully completing the tasks. Individual #268 frequently walked about campus. In an attempt to get him actively engaged in work, he was scheduled to begin working on the campus beautification team for half hour periods of time. Interviews with staff clearly revealed a strong commitment to identifying jobs that would meet an individual's interests and strengths. The Education and Training Assessment was provided for 14 of 16 individuals in the sample. The exceptions were Individual #297 and Individual #298 who were not participating in the classroom programs. These assessments reported on the individual's attendance and progress on specified skill acquisition plans. Other information was quite redundant as it was found in other documents including the ISP. The majority of the SAPs that were reviewed indicated a training schedule of one time per week. These also were not observable and measurable terms as all indicated that the individual would complete a specific number of steps in a task analysis. This did not clearly describe the skill the individual was learning to perform. In sum, it might be best to fold the report of progress into the Integrated Monthly Report. Unless, the assessment provides information beyond what is included in the Functional Skills Assessment and/or Vocational Assessment, this document might not contribute to the individual's comprehensive support plan. Minutes from two meetings of the Assessment Review Committee also were reviewed. This committee recently had been created to serve as an internal peer review for assessments, including but not limited to Functional Skills Assessments, Education and Training Assessments, Speech Assessments, and Vocational Skills Assessments. Participation in the two meetings reviewed was as follows: Director of Education and Training (100%), QIDP Coordinator (100%), QIDP Educator (100%), QIDP (100%), RN Case Manager Supervisor (100%), two to four Assessment Writers (100%), Admission and Placement Director (50%), Program Compliance Monitor (50%), and Habilitation Therapies (50%). Thoughtful feedback was evident in the meeting minutes and at the meeting the Monitoring Team attended the week of the visit. Based upon the information reviewed above, the Facility remained out of compliance with this provision of the Settlement Agreement.	

S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	The Monitoring Team requested three consecutive Monthly Reviews for the 16 individuals in the sample. These were provided for 15 of the 16 individuals in the sample. The exception was Individual #333 for whom two monthly reviews were provided. This document provided a review of progress on all ISP action plans (excluding action plans included in IHCPs), including service objectives and skill acquisition plans. Graphs depicting progress on the latter were also included. This was followed by summary information in the following areas: review of strengths and preferences, restrictive practices, review of observation notes, review of integrated progress notes, ISP addenda, life changing events/status of change, illnesses/hospitalizations, medication changes, medical/dental appointment refusals, desensitization, peer to peer aggression, restraint, level of supervision, behavioral health, injury trending, incidents/ANE allegations, PNMP/indirect supports, assessments/evaluations, class and/or work refusals, and additional comments/recommendations. This cumulative record of the individual's progress on his/her current ISP should prove to be a valuable tool in ensuring ongoing access to adequate habilitation programming. Specific feedback is provided below: ▪ Facility staff should carefully proof all documents to ensure that there is correspondence between the information provided in the text and graphs. An example where there was a lack of correspondence was in the October review for Individual #297. The text noted that she had completed four trials of her time management SAP while the graph indicated she had completed 29 trials. ▪ Facility staff should ensure that graphs depict data up to the current month only. For several individuals, monthly reviews included data from future months. Examples include: Individual #58 (November review); Individual #159 (December review); Individual #310 (October review); Individual #307 (November review); Individual #146 (December review); Individual #237 (January review); and Individual #77 (October and November reviews). ▪ When there was a lack of progress, the individual's team should meet to review potential reasons for the lack of progress, and take action as necessary. The program might require revisions or an alternative skill might be a more appropriate choice. Examples where problems were noted included the following: o In the October review for Individual #297, it was noted that she had not	Noncompliance

		made any progress on her self-administration of medication SAP for four consecutive months. The plan was not revised until December. o Individual #58 had made no progress for five consecutive months on his money management SAP. It was agreed that this would be addressed at his December ISP meeting. o In October it was reported that Individual #296 had made no progress on his healthy foods SAP for three consecutive months. For two consecutive months, it had been noted that the team would meet to consider revisions to this plan. No revisions were noted in the November review, rather there was a note that this would be reviewed at his ISP in December. His December review included this same statement, although his ISP meeting had been held prior to the end of the month. o The graphs displayed in the October review for Individual #77 indicated that she had made no progress on her pre-money management SAP or her pre-self administration of medication SAP for five and four months respectively. It was noted that her SAPs were reviewed at her ISP meeting in October. ▪ All recommendations should be addressed in a timely manner. Examples where problems were noted included the following: o For three consecutive months, it was noted that Individual #298 would be scheduled for a community trip to get her eyeglasses adjusted. It is suggested that this healthcare matter should have been addressed immediately. o In the November review for Individual #159, it was noted that the Human Rights Committee had approved her rights restriction on 8/12 with an expiration date of 11/12. It was agreed that a new rights restriction would be sent to HRC. This same note was included in her December review. o For three consecutive months, it was noted that: "baseline trials of desensitization (were) recommended." There was no indication that this matter had been addressed. ▪ Individual specific concerns included the following: o The November review for Individual #298 noted that there were no data available for the month as new SAPs were being implemented following her recent ISP meeting. Her ISP was not held until December. As noted, this cumulative review will allow an individual's team to recognize progress or the lack thereof and take steps accordingly. Timely response should ensure appropriate delivery of comprehensive habilitation services. Although the Facility was making progress in assessing its provision of habilitation	

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<tr><td></td><td></td><td>services for individuals served, programs were not consistently implemented or revised as necessary. Skill training programs were limited in number and often were scheduled to occur infrequently. For these reasons, the Facility remained out of compliance for this provision of the Settlement Agreement.</td><td></td></tr>
<tr><td></td><td>(b) Include to the degree practicable training opportunities in community settings.</td><td>The Facility provided a list of community training opportunities that occurred over a six-month period (i.e., 8/13 to 1/14). The following summarizes this training:

<table><tr><th>Unit</th><th>Number of Individuals</th><th>Range of Visits</th><th>Average Number of Visits</th></tr><tr><td>Atlantic</td><td>74</td><td>4 to 24</td><td>21</td></tr><tr><td>Coral Sea</td><td>67</td><td>1 to 6</td><td>2.7</td></tr><tr><td>Pacific</td><td>72</td><td>5 to 35</td><td>13.4</td></tr></table>
The Facility is commended for conducting some training opportunities in the community. Impediments to community outings were noted and steps were taken to address at least some of these matters. Additional para-transit drivers were trained and winter ponchos were obtained for individuals during particularly cold weather. Community integration specialists worked with the different units and active treatment coordinators assisted with outings. The Facility continued to track community outings and training opportunities. Corrective action plans were developed as appropriate.

Although it was clear that community-based training was occurring, it remained limited for many of the individuals residing in the Facility. For this reason, the Facility remains out of compliance for this provision of the Settlement Agreement.</td><td>Noncompliance</td></tr>
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SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Policy Number: Section T, effective 10/18/13, implemented 11/18/13; o Community Placement Report for period between 8/1/13 and 1/31/14, dated 2/8/14; o List of individuals currently referred for community placement, dated 2/8/14; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed since the last review, undated; o List of individuals who have requested community placement, but have not been referred, dated 2/14/14; o List of those individuals who have not been referred solely due to LAR preference, whether or not the individual himself or herself has expressed a preference for referral, dated 2/10/14; o List of individuals discharged pursuant to alternate discharge, dated 2/8/14; o Annual Report: Obstacles to Transition Statewide Summary, Fiscal Year 2013, data as of 8/31/13; o List of training/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices related to community transition for past 12 months, including to sign-in sheets; o List of all training and educational opportunities that address community living, including but not limited to provider fairs, community living option in-services, and/or onsite visits to community homes and resources provided to Facility staff; o Facility and Local Authority staff training curricula related to community living, transition and discharge, including training materials; o Documents or materials provided to staff to inform them of community living opportunities; o Community Living Discharge Plans (CLDPs), including individuals' most recent ISP and related assessments for Individual #61, Individual #55, Individual #34, and Individual #87; o CLDP for Individual #313; o List of alleged offenders, dated 2/8/14; o Description of minutes between the QA Department and Admissions/Placement Department; o List of community tours, from 2/1/13 to 1/31/14; o For the last one-year period, a list of individuals who have transitioned to the community indicating whether or not since their transition, 1) had police contact, and if so the reason why, the date, and an indication of whether or not they were arrested or otherwise detained; 2) had a psychiatric hospitalization, including the date on which they were hospitalized and the length of stay; 3) had an ER visit or unexpected medical

	hospitalization, including the reason; 4) had an unauthorized departure, including the date and length of departure; 5) been transferred to different setting from which he/she originally transitioned, including both addresses and reason for transfer; 6) died, including the date of death and cause; and/or 7) returned to the Facility, including the date of individual's transition to the community, date of return, and reason, undated; o Individual Support Plans, Sign-in Sheets, and Assessments for the following: Individual #159, Individual #285, Individual #141, Individual #297, Individual #296, Individual #298, Individual #359, Individual #146, Individual #310, and Individual #77; o List of Post Placement Monitoring, dated 2/8/14; o Pre-Move and Post-Move Monitoring documentation for the following: Individual #34, Individual #61, Individual #55, Individual #323, and Individual #112; o Last 10 monitoring tools completed by: a) Admissions Placement Coordinator; and b) Quality Assurance Department staff, various dates; o Based on monitoring data and/or key indicators related to the provision of supports in the most integrated setting, reports showing analysis of such data, as well as descriptions of actions taken or corrective action plans developed; o For Individual #47, documentation related to death after a community placement; o State Office review of the CLDPs for: Individual #61, Individual #34, and Individual #55; o For the following individuals, the 14-day Living Options ISPA, and any subsequent ISPAs related to transition: Individual #161, Individual #119, Individual #48, Individual #59, Individual #154, and Individual #308; o For the following individuals, ISPAs related to transition for the past year: Individual #61, Individual #55, and Individual #34; o Post-move monitoring report for Individual #34; o For last six months, minutes of meeting between Facility staff and Local Authority (LA); o Updated list of obstacles to transition, dated 4/3/14; o Most recent Section T monitoring tools; o ISPAs for Potentially Disrupted Transitions and evidence of completion of recommendations, as available, for: Individual #55, Individual #94, and Individual #47; o Updated Community Placement Report, for period from 3/1/13 to 2/28/14; o CCSSLC Self-Assessment for Section T, updated 3/14/14; o Action Plan for Section T; o CCSSLC Provision Action Information for Section T; and o Presentation Book for Section T. ▪ **Interviews with**: o Esmerelda Vogt, Admissions Director; o Monica McDermott, Post-Move Monitor (PMM); o Laura Maldonado, Placement Coordinator; o Elena Martinez, Program Compliance Monitor; and o Rachel Martinez, QIDP Coordinator. ▪ **Observations of**: o ISP meeting for Individual #184; and

	○ Post-Move Monitoring visit for Individual #34.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 3/14/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The Facility had considerable work to do with regard to its self-assessment activities for Section T. As discussed with regard to Section T.1.f, the Facility had completed limited monitoring for Section T, so it was unclear from where some of the data in the Self-Assessment was derived. Although some relevant data from other sources was sometimes included (e.g., data related to number of community education tours), the data was not linked to outcome measures or goals to determine whether or not the Facility was doing well. The Self-Assessment frequently did not review the quality of supports or activities (e.g., for T.1.b.2, there was no review of the quality of individualized plans to address education on community options). The validity of the Facility's self-assessment activities was problematic. The Facility rated itself as being in substantial compliance with the following sub-sections of Section T: T.1.b, related to policies regarding the most integrated setting; T.1.c.1, related to the coordination with the community providers on the development of CLDPs; T.1.c.1, related to the CLDP process and coordination with provider staff; T.1.c.2, which requires specifying staff responsible and timeframes for completion of action steps in CLDPs; T.1.c.3, which requires teams to review CLDPs with individuals and their LARs; T.1.e, which requires the development of comprehensive CLDPs and review of pre-move supports; T.1.f, related to quality assurance processes; T.1.g, related to obstacles to referral and transition; T.1.h, which requires the Facility to provide a Community Placement Report; T.2.a, related to post-move monitoring and follow-up; and T.4, related to alternate discharges. However, the Monitoring Team found the Facility in substantial compliance with the following sub-sections: T.1.c.1, T.1.c.2, T.1.h, and T.2.b.
	Summary of Monitor's Assessment: Individuals' ISPs continued to not consistently identify all of the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation. It is essential, as teams plan for individuals to move to community settings, that ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services, and that, as appropriate, these be transitioned to the community through the community living discharge plans. Systemic issues negatively impacted referrals and had not been addressed, including, for example: ▪ Gaps or perceived gaps in supports in the community for individuals with complex behavioral and/or medical and physical and nutritional management needs; ▪ For some individuals, a factor delaying referrals were the institutional practices, such as different traffic rules, on the campus that allowed individuals to become accustomed to a different set of expectations than are found in typical communities. Based on these institutional practices, teams concluded that the Facility was the "least restrictive alternative" for the individuals; and ▪ For some individuals, teams had historically failed to educate them about options, and now concluded that because the individuals did not understand the options available to them and/or

	teams did not know their preferences, they should not be referred for community transition. At the Facility-level, teams continued to not fully identify or justify the obstacles to referral. In addition, although teams were developing action plans to address obstacles to referral, they were not individualized. The State Office's annual report on obstacles to referral and transition provided limited information about steps the State was taking on a systemic level to overcome obstacles, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. Although most assessments prepared for individuals' ISPs included recommendations related to their appropriateness for transition to the community, some assessments still did not include this information. In addition, although professional members of the team were making and documenting a joint recommendation in the ISP, sufficient justification for the recommendations often was not found, and/or reconciliation between the various team members' written recommendations was not documented. Community Living Discharge Plans continued to inadequately define the necessary protections, supports, and services to ensure the individual's health and safety, and limited progress had been made in this regard. Most of the issues identified in the Monitoring Team's previous reports regarding deficiencies with the CLDPs had not yet been rectified. As a result, individuals transitioning to the community were potentially at risk due to the lack of adequately planned and implemented protections, services, and supports. Post-move monitoring had been completed in a timely manner for all of the individuals who had transitioned to the community. Some concerns were noted with regard to the thoroughness of the post-move monitoring activities to confirm the provision of pre- and post-move supports, and substantiate the findings (e.g., interviews, document reviews and observations). In addition, concerns were noted with regard to the involvement of IDTs in the Facility's efforts to take reasonable action to correct deficiencies noted.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist	Based on the Community Placement Report, for the time period between 3/1/13 and 2/28/14, as well as other lists the Facility provided, the transition-related numbers were as follows: ▪ Since the last review in September 2013, seven individuals had transitioned (approximately 3% of the population); ▪ Referrals for community placement: o Eighteen individuals were on the active referral list (8% of the current census of 231 individuals);	Noncompliance

#	Provision	Assessment of Status	Compliance
	individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	○ Four individuals were referred since last visit; ○ Nine individuals had been on list more than 180 days; and ○ Five individual had been on the list for more than one year; ▪ Reportedly, 20 individuals had requested/preferred placement, but were not referred; ▪ The Community Placement Report did not yet include data regarding the numbers of individuals that would have been referred, except for the preference of the LAR. However, another document included the data for a six-month period of time. For ISPs held between 8/1/13 and 1/31/14, a total of 33 individuals would be referred except for LAR preference (i.e., the IDT would refer); ▪ Since the last review, no individuals' referrals were rescinded (i.e., although one individual was listed, he was on a 90-day respite, as a result would have been considered an "alternate discharge" according to the Settlement Agreement); ▪ It was unclear whether or not the Facility provided a full list of potentially negative outcomes, because the Facility labeled the list it submitted as "Any tracking data for individuals who have transitioned to community since Monitoring Team's last visit including hospitalizations, ER visits, and 911 calls." This was not responsive to the Monitoring Team's request. However, based on the list the Facility provided, potentially negative outcomes included (the Facility's compliance related to review of these is addressed with regard to Section T.1.f): ○ No individuals had returned from community placement; ○ One death had occurred following community placement (i.e., Individual #47 was struck by a car while attempting to cross the freeway); and ○ One other potentially negative outcome (e.g., Individual #353 had surgery to repair a broken ankle after another individual fell on him at the day program); and ▪ One individual was discharged pursuant to Section T.4. As is discussed with regard to Section T.1.b.3, the determinations of professionals regarding individuals' transition to the most integrated setting appropriate to their needs continued to be an area requiring focused efforts. Individuals' ISPs generally included a recommendation from the Facility's team members' with regard to whether or not community transition was appropriate. Unfortunately, the assessments and/or ISP narratives often did not include sufficient justification for the teams' recommendations. <u>Placement and Referral Not Opposed</u> a. In reviewing the CLDPs and ISPs for three individuals who had been placed (i.e., Individual #61, Individual #55, and Individual #34), three (100%) individuals	

#	Provision	Assessment of Status	Compliance
		and/or LARs did not oppose transition to the community. <u>Responding to Individual Requests and Rescinded Referrals</u> b. According to documentation the Facility provided, since the last review, there no rescinded referrals. As a result, the following metrics were not applicable: ▪ Of these, the reasons for the rescinding appeared to be reasonable for ___ (%). ▪ Further, an adequate review to determine if changes in the referral and transition planning processes at the Facility was conducted for ___ (%) of the rescinded referrals. ▪ Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for ___ (%). c. Reportedly, 20 individuals requested placement, but were not referred. ▪ Of the nine individuals who requested placement, but were not referred, nine individuals had an LAR who made this decision. ▪ Of the remaining 11 individuals, it did not appear that an appropriate review, appeal, and/or lack of consensus review was conducted. <u>Systemic Issues</u> d. There were systemic issues delaying referrals (at the State and/or Facility level). There were actions to resolve some, but not all of them. For example: ▪ Based on review of a sample of 10 ISPs, the lack of or the perception of a lack of supports in the community for individuals with complex medical and/or physical and nutritional management needs, and/or complex behavioral needs were systemic issues delaying referrals. Some examples included: o The ISP narrative related to Individual #297's preferences stated: She stated she would like to live in the community and have her boyfriend who also resides at the CCSSLC move with her at [sic] a co-ed group home. [Individual #297] understand [sic] she must improve her behavior and not pull out her G-tube." Later in describing the guardian's preferences, the ISP stated: "He stated he felt she needed to continue to live at the CCSSLC as [Individual #297] frequently pulls out her G-tube." There is no reason that such a behavioral issue could not be addressed in a community setting. o For Individual #159, the team discussed that she would need a "PICA home." The narrative stated: "During the meeting, the Local Authority said there were no areas in Corpus Christi that were specialized in this area (PICA)." However, this was not addressed as an obstacle, and the plan in the ISP did not identify the specific need to identify a provider that could work with an individual with pica effectively.	

#	Provision	Assessment of Status	Compliance
		Based on discussion with Facility staff as well as the Monitors' recent discussions with the parties, systemic actions to resolve these issues were not being implemented. ▪ For some individuals, a factor delaying referrals were the institutional practices, such as different traffic rules, on the campus that allowed individuals to become accustomed to a different set of expectations than are found in typical communities. Based on these institutional practices, teams concluded that the Facility was the "least restrictive alternative" for the individuals. For example: o For Individual #296, the team jointly concluded that: "[Individual #296] cannot be served in a less restrictive setting at this time… The team agrees that [Individual #296's] current living environment is less restrictive than a community setting, as [Individual #296] currently is full routine [level of supervision] and has the ability to come and go as he chooses; this would not be possible in a community setting, as it would pose immediate threats to his safety. The team agrees that currently [Individual #296] lacks the ability to understand the differences in his living environment options. The team agreed that by introducing him to different environments, such as adding him to the LA group home tour list, we can begin to increase his knowledge base in that area, with the hopes of possible referral in the future, when his safety can be better ensured." It was unclear why the team believed that supports could not be provided in a community setting to allow Individual #296 to access the community when he wanted to. In addition, the team put no action plans in place to teach Individual #296 better safety skills in the community, and clearly this had been an issue for a number of years, and the team had not effectively addressed it. ▪ For some individuals, teams had historically failed to educate them about options and/or teams did not know their preferences, and now concluded that because the individuals did not understand the options available to them, they should not be referred for community transition (e.g., Individual #146, Individual #296, and Individual #77). For these individuals, individualized, aggressive plans to educate them about options were not found in their ISPs. e. Based on review of documentation and interviews with staff, there were potential systemic issues delaying transitions (at the State and/or Facility level). Based on information provided, it did not appear that specific actions had been identified and/or were in the process of being implemented to resolve them. For example: ▪ For approximately four of the individuals on the referral list, behavior supports were listed as the obstacle to transition. For example, for individuals with pica, at least the perception was that supports in the community were difficult to identify to ensure in which they lived and worked/attended day program were	

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		safe. ▪ Four individuals had specialized medical supports listed as the obstacle to transition. ▪ Five individuals had environmental modifications listed as the obstacle to transition. ▪ For eight individuals, the obstacle to transition was limited residential opportunities in the preferred area. f. Funding availability was not cited as a barrier to individuals moving to the community. g. Senior management at the Facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list. The Admissions Placement Coordinator presented information regularly at the QA/QI Council meetings. <u>Pace of Transitions</u> h. At the time of the review, transitions were not occurring at a reasonable pace. ▪ Of the seven individuals placed since the time of the last onsite review, one (14%) was placed within 180 days of his referral. ▪ At the time of the review, 18 individuals had been referred for community transition. Nine of these 18 individuals had exceeded the 180-day timeframe. o Of these, five individual had exceeded one year. Based on the ISPAs related to transition for a sample of three individuals that had been on the referral list for over 180 days (i.e., Individual #161, Individual #119, and Individual #48): i. For none of the three (0%) individuals reasonable activity and actions had occurred related to the transition and placement the individuals that had exceeded the 180-day time period j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for none of the three (0%) individuals. In other words, for all of the individuals, there were gaps of time in which little to no activity occurred. k. Adequate justification was provided for the lengthier transition process for none of the three (0%) individuals. Some examples of problems included: ▪ For Individual #161, an ISPA meeting was held on 5/2/13. Although the team met, it was unclear how much detail was discussed regarding his transition planning, because the shell of the 14-day meeting was largely blank (i.e., just the questions/probes from the shell with no individualized information included). Based on ISPA documentation, the team did not meet again regarding transition	

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		until 1/29/14, after a community tour had occurred. Although the Transition Specialist submitted documentation showing additional activity between August 2013 and January 2014, it was unclear what, if any activity occurred between March 2013 and August 2013. ▪ Although the team for Individual #119 recognized that his transition might take longer due to his need for a slower process, the documentation submitted did not show consistent efforts on the part of the team to move towards transition to the community. His referral was made in September 2012, and the ISPAs showed a total of four team meetings related to transition since then, with little activity documented. Although the Transition Specialist submitted documentation showing additional activity between August 2013 and January 2014, it was unclear what, if any activity occurred between September 2012 and August 2013. ▪ Although Individual #48 was unsure about whether or not he wanted to transition, it was not clear from the documentation provided what specific actions the team was taking to address his specific questions or concerns, and provide him with opportunities to visit various providers that could meet his needs. No information was submitted from the Transition Specialist. The Facility remained out of compliance with this overarching provision of Section T of the Settlement Agreement.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	a. The State Office policy for most integrated setting practices was recently issued. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: ▪ The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy described the process of team members making recommendations in their assessments (at III.C.5.c), but did not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addressed, in very global terms, a "living options discussion," and referred the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: “Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spelled out how this would be done. ▪ There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference).	Noncompliance

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		▪ The policy did not thoroughly address the IDT and Facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. ▪ There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). ▪ After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. ▪ The policy did not mention the Settlement Agreement requirement that action be taken prior to the individual's move if pre-move supports are not in place. ▪ The policy did not address the quality of CLDPs. ▪ There was no mention of need for IDTs to use CLDP to ensure supports are in place. ▪ There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. ▪ The policy should draw from, and line up with, the metrics submitted by the Monitors and the content of the monitoring reports. b. At the time of the review, the Facility did not have a local policy on the most integrated setting. On 10/19/13, the Facility had adopted the State Office policy, and the development of a local policy was included in the Facility's action plans. As Facility staff recognized, the Facility should have policies and procedures that operationalize/define implementation of the parts of the State policy that are not specific. For this policy, examples include, but are not limited to the way in which community tours are managed, how educational activities are presented to individuals, expectations regarding staff training on the most integrated setting, how the Admissions and Placement Department staff ensure that all supports and services are included in CLDPs, the expectations regarding quality assurance efforts for this section at CCSSLC, and which staff are to review the CLDP prior to its submission to the Facility Director. The Facility provided documentation that on 11/12/13, all 13 QIDPs, 31% of the Behavioral Health Specialists, and 46% of RN Case Managers had been trained on the State Office policy on Most Integrated Setting. Based on discussion with the Admissions Placement Coordinator, there had been some turnover, and further training was needed. The parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells	

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		under T.1.b. The Facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The specific requirements of this provision are discussed below, including: 1) the identification in the ISP of the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs; and 2) identification of the major obstacles to the individual's movement to the most integrated setting, and identification and implementation of strategies to overcome such obstacles. <u>Identification in ISPs of Needed Protections, Services, and Supports</u> a. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F.1.d, F.2.a.1, and F.2.a.3. As noted in Section F, substantial compliance was not found for F.1.d, F.2.a.1, and F.2.a.3. As has been reiterated since the baseline review, it is essential, as teams plan for individuals to move to community settings, that ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. This is important for three reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them, as well as potential providers, to have a clear idea about what protections, supports, and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals served by CCSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the ISP will be the key document that is used to ensure that pre-move required supports are identified and in place prior to an individual's move, and post-move required supports are identified and provided in a timely and complete manner. <u>Identification of and Plans to Overcome Obstacles to Referral and Transition to Community</u> Regarding referral at the individual level: b. Of the 10 ISPs reviewed, nine should have had obstacles to referral defined (the other individual, Individual #310, had been referred for transition to the community). Of the remaining nine ISPs, five (50%) included an adequate list of obstacles to referral (i.e., Individual #285, Individual #141, and Individual #298, all of whom the obstacle was LAR Choice and/or Individual Choice, and as noted below, although this was accurate, for	Noncompliance

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		most, the teams had not identified the specific reasons; Individual #359, for whom the court would not allow placement; and Individual #297, who had multiple obstacles listed). The problems associated with the obstacles in the plans included the following: ▪ When guardians or individuals objected, adequate inquiry generally did not occur with regard to specifically what their concerns were (e.g., Individual #285, and Individual #141). This is very important information to collect and analyze, but it did not appear it was being captured regularly. ▪ For some individuals, the teams' justifications for identifying some obstacles were not clear (e.g., although "Medical Issues" were identified as the obstacle, no specifics were provided about what medical supports Individual #159 needed that could not be provided in the community). ▪ At times, obstacles that should have been identified were not (e.g., Individual #159's team had discussed the fact that she needed a provider that could address her pica behavior, and the LA indicated this was a difficult need to meet, but it was not identified as an obstacle; and for Individual #296, the only obstacle identified was the individual's lack of understanding of community living options, but another obstacle was the institutional practices that had led to Individual #296 not being safe in community settings where traffic rules, etc. were different). ▪ At times, the teams identified "Individual Choice – lack of understanding" as the obstacle (e.g., Individual #146, Individual #77, and Individual #296). However, teams had failed to develop and/or implement plans to educate individuals about their options in any meaningful way, and/or, according to the individuals' Rights Assessments they lacked the ability make informed decisions regarding programming. Although determining their preferences was important, for some individuals without guardians, teams or the Facility Director will need to make the decision about referral. c. Of the one annual ISP meeting observed (i.e., Individual #184), an adequate list of obstacles to referral was identified for none (0%). Individual #184 had had a guardian, but the guardianship had lapsed. This meant that in the past, a court had deemed Individual #184 unable to make decisions about programming, including where to live. The team identified the only obstacle as "Individual Choice – Lack of understanding." Although determining his preferences would be important, he was unable to make a decision about transition on his own, and without a guardian, the team should have made the decision. Given that all team members believed he could be supported in a less restrictive setting, it was not clear why a referral was not made, but it appeared the team continued to rely on the former guardian's wishes. Regarding a plan to address obstacles at the individual level: d. Of the nine ISPs, five (56%) (i.e., Individual #285, Individual #296, Individual #359,	

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		Individual #146, and Individual #77) included an action plan to address/overcome obstacles identified. Of these five, one (20%) (i.e., Individual #359) was adequate (i.e., were individualized, measurable, and comprehensively addressed the obstacles). Individual #359 had court involvement, and the plan was to continue to provide updates to the court. However, most ISPs did not include plans that addressed the specific obstacle(s) the team had identified, but rather included generic efforts to provide more information to the individual and/or guardian about community options. e. Of the one annual ISP meeting observed, a plan was included to address/overcome the identified obstacles for one (100%). Of the one plan, one (100%) appeared adequate. In order for plans to be considered "adequate," the written plans would need to be measurable, and individualized. Based on the discussion that the team had, they came up with an individualized plan that involved team members accompanying Individual #184 on visits to small ICF/ID homes in the community, and involving his mother and potentially his sister. The team discussed the need to provide information to the family members to update their knowledge about what the community could offer Individual #184. Although the Monitoring Team did not have the final written plan to review, if the plan discussed at the meeting was correctly memorialized in the ISP document, then it was both individualized and measurable. Regarding transition at the individual level: As discussed while on site, the Facility was not yet identifying obstacles to transition from the beginning of the transition process, but only after individuals had been referred for more than 180 days.: f. Of the three CLDPs and related ISPAs reviewed, at least two individuals (i.e., Individual #34 and Individual #55) should have had obstacles to transition defined. Based on review of these individuals' CLDPs and ISPA related to transition, none (0%) included an adequate list of obstacles to transition. As a result, the following could not be assessed: g. For this ___ individual, ____ of the ISPAs (___%) had action plans to address the obstacle to transition. Preferences of individuals: h. Of the ten ISPs, three (30%) (i.e., Individual #297, Individual #359, and Individual #310) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). i. Of the one annual ISP meeting observed, the individual's preference for where to live was adequately described in none (0%), and this preference appeared to have been	

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		determined in an adequate manner for none (0%). The team for Individual #184 did not yet have a good idea of what his preferences were. Although the guardian, whose guardianship had now lapsed, had prevented the team from involving Individual #184 on community group home tours in the past, it was unclear why the team was unable to describe in any detail they type of living environment Individual #184 would prefer. Preferences of LARs: j. Of the four ISPs for individuals with guardians (i.e., Individual #285, Individual #141, Individual #297, and Individual #298), one (25%) included an adequate description of the LAR's preference and how that preference was determined by the IDT (i.e., Individual #141, for whom the LAR's concerns related to community transition were discussed in some detail). k. Of the one annual ISP meeting observed, the individual did not have an LAR (i.e., Individual #184's guardianship had lapsed). As a result, the following indicators were not applicable: The LAR's preference for living setting was adequately described in ___ (___%), and this preference appeared to have been determined in an adequate manner for ___ (___%). CCSSLC had made limited progress with regard to identifying obstacles to community referral and transition, and more work was needed. Although obstacles were being identified, they were not consistently accurate, and more work was needed to determine the specific concerns of individuals and their guardians when their choice was the reason for a referral not being made. Individuals frequently did not have plans to address the specific obstacles identified, and the quality of the plans teams had developed to overcome such obstacles remained inadequate. Although plans were measurable, they continued to lack individualization. These deficiencies, in addition to ISPs that did not adequately identify individuals' needs for protections, supports, and services, resulted in a finding of noncompliance with this provision of the Settlement Agreement.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	<u>Individualized Plans</u> a. In reviewing 10 recently completed ISPs, one individual (i.e., Individual #310) had been referred for transition to the community, and was engaged in the CLDP process; and one individual was not eligible for community transition due to court-imposed restrictions (i.e., Individual #359). For the remaining eight, seven (88%) had a plan that addressed education about community options. The individual that did not have a plan was Individual #298. Of these seven, none (0%) were adequate. Although most were measurable, none were individualized. The one that was not measurable was the one for Individual #296. The most challenging area with regard to education of individuals and LARs/families is	Noncompliance

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		individualizing this process, and documenting that individuals and their guardians are making informed decisions. Many examples of concerns related to the plans have been discussed in previous reports, and little change was seen in this most recent sample of ISPs. As indicated in the Monitoring Team's previous reports, the action plans developed did not, for example, target specific types of providers for community tours, identify research that the team would do to answer the individuals or their guardians' specific questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans using the information that the team is able to gather about the reasons for the individual, family member, or LAR's reluctance and/or the team's concerns. For example, if an LAR has questions or concerns about the specific supports available in the community, identifying providers with expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. When teams have questions about availability of supports in community settings, these should be researched. At the time of the review, these types of activities were not included in action plans. Creative ideas and brainstorming within CCSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. <u>Provider Fair</u> b. The Facility had held a provider fair within the past 12 months. CCSSLC continued to hold two provider fairs each calendar year. The last one was held on 12/4/13. Anecdotally, based on discussions with Admissions Placement staff, a number of individuals made connections with providers during the Provider Fair that ultimately were the providers they selected to transition with into the community. Admissions Placement staff named approximately five individuals for whom this was the case. The Facility did not present evidence to show that it had measured and evaluated outcomes, and used the information to make changes for future fairs. Based on data in the Facility's Presentation Book for Section T, participants at the December 2013 fair included 85 individuals, no family members or guests of individuals, and 104 Facility staff. Participants were asked to conduct evaluations, but based on staff report, not many were completed. However, it was unclear if this data was reviewed to determine whether or not changes should be made. <u>Local Authority</u> c. The Facility appeared to maintain good communication and a working relationship with the LA, participated in at least quarterly meetings with the LA (i.e., based on meeting minutes that showed monthly meetings), and ensured relevant topics were on the agenda for the LA meetings. Based on interview with staff and meeting minutes, a	

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		group of Facility staff was meeting with Local Authority staff approximately monthly. From the Facility, this generally included the Admissions Placement Coordinator, the Post-Move Monitor, and Transition Specialist(s). Based on the minutes, the group discussed individuals that had been referred to the community, provider fairs, and different ways to offer education about community living options to individuals and their correspondents, such as virtual tours. <u>Tours of Community Providers</u> d. The Facility did not yet have an adequate system to track and manage tours of community providers (i.e., identified all individuals for whom a tour was appropriate, and identified all individuals and whether or not each went on a tour). Based on review of individuals' ISPs, teams frequently included community tours as an action step to provide individuals with greater exposure to options available in the community. However, as discussed above, such action plans often were not individualized, and so the appropriateness of the tours on which individuals participated could not be assessed. Based on data the Facility provided, between 1/4/13 and 1/10/14, 11 community provider tours were conducted. When asked for "over the last one-year period, the unduplicated number of individuals that have participated in CLOIP tours," the Facility produced a list of each tour and the individuals that attended, but did not provide an unduplicated count of individuals (i.e., often individuals were listed more than once, and a total number of individuals that had been on one or more tour was not provided). In addition, because a functioning system for tracking tours required per individuals' ISPs versus tours completed, the following indicator could not be completed: e. Based on the Facility's own report, of the ____ individuals at the Facility for whom a tour was appropriate, ___ (%) went on a tour appropriate to their needs within the past year. On a positive note, the Facility had worked with the Local Authority to expand the options available to individuals in terms of tours of community homes and programs. The Facility staff and Local Authority staff recognized that many of the providers in the Corpus Christi area had hosted many tours, and some were becoming reluctant to continue to host as many as they had been. Since the last review, the Facility and LA had worked to identify providers in counties in the surrounding area, and had begun to schedule day trips to homes and programs within a short drive. This required coordination with Residential Services. Initially, it appeared to be working well, and it provided individuals and the staff accompanying them with information about different options in the community.	

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		f. For the individuals in the sample, the ISPs generally did not provide sufficient information to determine if an action plan for a community provider tour had been included in the previous ISP and if so, if such a tour(s) had occurred and was tailored to their needs. However, for one individual (i.e., Individual #298), it was clear there was not plan due to the LAR's refusal. For one individual (i.e., Individual #359, it appeared the plan had been implemented. For two individuals, their ISPs indicated the plan from last year had not been fully implemented (e.g., Individual #77, whose team documented the plan was not implemented from the previous year, but cited the individual's lack of knowledge about community options as a reason not to make a referral; and Individual #146, whose plan was only partially implemented). The ISP for one individual (i.e., Individual #141) indicated he had been on a community tour, but it was not clear what the specific requirements in last year's plan were, and the tour clearly was not tailored to meet her need for an accessible home. As a result of the limited information for many individuals in the sample, the following could not be completed: ▪ Of the ___ individuals in the sample for whom their teams had determined a tour was appropriate, ___ (___%) went on a tour tailored to their needs within the past year. <u>Visits to Friends in the Community</u> g. Although the Transition Specialist was trying to make some efforts in this regard (e.g., facilitate sharing of telephone numbers and addresses), the Facility did not have a process to identify individuals who would benefit by visiting friends who had moved to the community, and a process for making it happen. <u>Educational Activities at/by Facility for Individual</u> h. Since the last onsite review, based on documentation the Facility provided, other educational activities for individuals did not occur during self-advocacy meetings, did not occur during house meetings for individuals, did not occur during family association meetings, and did not occur during other appropriate situations or locations. The Admissions Placement Department recognized the need to improve educational opportunities, and recently had initiated an Education Committee. Some ideas were in the works, such as the development of a newsletter that the Admissions Placement Department would issue. The hope was that with the assistance of this Committee as well as a new Transition Specialist (i.e., one Transition Specialist had moved to the Post-Move Monitor position), more focus could be placed on education related to community options. <u>Educational Activities for Staff</u> The Facility was able to provide some information about staff participation in education activities related to community options. For example:	

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		▪ The Facility provided data to show that between 8/5/13 and 1/6/14, 196 out of 213 new employees (92%) had participated in the New Employee Orientation module related to the most integrated setting. ▪ On 9/17/13, the Local Authority provided training to approximately 57 staff. ▪ At the December 2013 Provider Fair, 104 staff participated. ▪ Staff also were participating in community provider tours. During upcoming reviews, the Facility will be asked to provide data for the following indicators: ▪ i. % of direct support professionals were documented to have participated in one or more activities (e.g., in-service, workshop, community tour). ▪ j. __ % of clinicians were documented to have participated in one or more activities (e.g., in-service, workshop, community tour) ▪ k. ___ % of managers and administrators were documented to have participated in one or more activities (e.g., in-service, workshop, community tour). l. Since the last onsite review: a) some information had not been shared about successful community placements with individuals who were reluctant to consider community placement (i.e., some individuals that had transitioned came back for the provider fair and shared their stories; but b) information had not been shared with LARs who are reluctant to consider community placement. Such activities should be individualized, but some additional ideas would include: as appropriate, the Facility should pair families/LARs who have experienced a successful transition with families/LARs who are reluctant; individuals who have experienced successful transitions could speak in other forums, such as at Self-Advocacy meetings; and newsletter articles could regularly highlight success stories. Although individuals often had a plan in their ISP, the plans were not individualized. The individualization of this process is key to ensuring that individuals and their guardians are provided education that allows them to make an informed choice, as required by the Settlement Agreement. The Facility needed mechanisms to track and manage the community exposure tours to ensure that individuals participated in tours that were tailored to their needs. The Facility needed to expand its efforts to provide individuals and families with varied opportunities to learn about community options. Staff educational opportunities related to the community needed to be tracked in a manner that would allow the Facility to determine which staff had been trained, and which still required training. Efforts to share success stories were needed, particularly for individuals and guardians who were reluctant. The Facility remained out of compliance with this provision.	
	3. Within eighteen months of	The Facility was implementing the State Office's process to have each professional	Noncompliance

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	the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	member of the IDT document his/her recommendation regarding the individual's ability to transition to the community in the assessments completed prior to annual ISP meetings. In addition, at the ISP meeting, the professional members of the team needed to make a recommendation to the individual/guardian. The most recent format of the ISP included a section that more specifically addressed teams' recommendations regarding transition to the community. a. Of 10 ISPs reviewed for which the Monitoring Team requested all assessments (i.e., Individual #159, Individual #285, Individual #141, Individual #297, Individual #296, Individual #298, Individual #359, Individual #146, Individual #310, and Individual #77), for none (0%), all of the assessments included the applicable statement/ recommendation. The assessments that did not include recommendations varied from individual to individual, and included: the Functional Skills Assessment, dental, nutrition, Behavioral Health Services, psychiatry, education and training, audiology, and nursing. Of note, at times the statements that were included either did not follow the State Office format (i.e., frequently the ones included in the SL and psychiatric assessments). Of concern, some assessments showed a lack of understanding of individuals' right to live in the most integrated setting and/or the supports that would need to be in place for an individual to be successful. For example: ▪ For Individual #159, the Behavioral Health Services Specialist did not appear to have a good understanding of the community options available, or the realities of service provision in the community. The assessor stated: "[Individual #159 is considered to be in good health and a functioning individual who will assist with her daily skills. She is diagnosed with Pica is [sic] this is definitely an issue that must be considered when selecting a group home. A Pica free environment will be ideal for [Individual #159] as she would no longer need a 1:1 supervision providing her with the independence she deserves. She must continue to receive psychiatric services but her PBSP can be exchange [sic] to a psychiatric plan if she moves to a Pica free home." These misunderstandings had the potential to place Individual #159 at significant risk. ▪ For Individual #146, the psychiatry recommendation read: "She might be able to go to a group home where all her needs must be met because [Individual #146] needs 24/7 care. In case she goes to a group home the arrangements must be made especially because of her condition. [Individual #146] is fragile with depression, as well as, possible psychosis in remission. So there is no issue of discharging her in the near future because we have to find a very highly structured environment for her." b. In none of the 10 (0%) written ISPs reviewed, and during one of the one (100%) annual ISP meetings observed, independent recommendations from each of the professionals on the team to the individual and LAR were included.	

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		c. In none of the ten (0%) written ISPs reviewed, and during none of the one (0%) annual ISP meetings observed, a thorough discussion of living options occurred. d. Three of the 10 individuals' ISPs (30%) a complete and adequate statement of the opinion and recommendation of the IDT's professional members as a whole was included (i.e., Individual #298, whose team recommended transition, but the guardian chose not to pursue transition; Individual #359, for whom court involvement precluded his movement to the community; and Individual #146, for whom the team recommended transition). Examples of the problems noted are discussed below: ▪ Individual #285's ISP included no recommendation. ▪ For Individual #159, according to the ISP narrative, the psychiatrist indicated that she could not be supported in a less restrictive setting, and the remaining team members said she could. However, this was not consistent with the assessments themselves. The following indicated she could not be supported in a more integrated setting: medical, psychiatric, and nutrition. These differences were not reconciled. The team concluded that the Facility discipline members "determined that [Individual #159] can be served in a less restrictive setting, but not at this time. This determination is based on Medical issues, [Individual #159] is currently hospitalized." The team was planning for the year, and it was unclear why a hospitalization was justification for not recommending referral to the community. ▪ For Individual #141, the narrative of the ISP indicated that all discipline team members except for medical recommended that she could be supported in a less restrictive setting. Based on review of the actual assessments, audiology also indicated she could not be supported in a less restrictive setting. The discipline recommendation was that she could transition to the community, but there was no description of the team's deliberation, or reconciliation of the discrepancy in team members' opinions. ▪ Based on the summary in the ISP, several assessors indicated they did not believe community transition was appropriate for Individual #297. For example, education and training, audiology, psychiatry, and medical all indicated she should not be referred. However, in summarizing the team's recommendation, the only assessor identified as not recommending community transition was audiology, and no discussion was documented regarding how the team addressed the discrepancies. The team concluded that the Facility discipline members determined that Individual #297 could be served in a less restrictive setting. ▪ In their assessments, all discipline members all indicated that Individual #296 could be supported in a less restrictive setting. However, they then jointly concluded that: "[Individual #296] cannot be served in a less restrictive setting	

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		at this time. This determination is based on discussion during the meeting. The team agrees that [Individual #296's] current living environment is less restrictive than a community setting, as [Individual #296] currently is full routine [level of supervision] and has the ability to come and go as he chooses; this would not be possible in a community setting, as it would pose immediate threats to his safety. The team agrees that currently [Individual #296] lacks the ability to understand the differences in his living environment options. The team agreed that by introducing him to different environments, such as adding him to the LA group home tour list, we can begin to increase his knowledge base in that area, with the hopes of possible referral in the future, when his safety can be better ensured." In addition to being unclear why all assessors said he could be supported in a less restrictive setting, and then changed their minds, it also was unclear why the team believed that supports could not be provided in a community setting to allow Individual #296 to access the community when he wanted to. In addition, the team put no action plans in place to teach Individual #296 better safety skills in the community. ▪ For Individual #310, the team made the referral, but stated: "This determination is based on the fact that a PICA free environment would best meet his needs." In the IRRF, the team repeatedly indicated that his level of restriction of one-to-one staff could not be reduced until he moved to the community to a pica-safe environment. This showed a lack of understanding of community environments, and the ongoing needs of individuals with pica. ▪ The Facility discipline members "determined that [Individual #77] can be served in a less restrictive setting at this time and do not recommend that [Individual #77] be referred for community transition. This determination is based on: [Individual #77] lacks the understanding of community living options." The team that went on to explain that because her action plan from last year had not been implemented as written, Individual #77 had not been adequately exposed to community options. In addition, the team concluded that Individual #77 "is non-verbal and is unable to indicate where she would like to live." The team included no methodologies in the action plan to determine Individual #77's preferences, and her Rights Assessment indicated that she did not have the ability to make informed decisions in any of the areas covered. As a result, although it was important to try to determine her preferences, the team acknowledged that she did not have the ability to make the decision on her own. As a result, the team and/or Facility Director needed to make the decision. e. In nine of the ten (90%) ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included. For Individual #285, the team did not specifically state a full team recommendation (i.e., none listed). However, of these, four (44%) included appropriate justification for the team's	

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		recommendation (i.e., Individual #141, Individual #298, and Individual #297, whose teams recommended transition, but the guardians chose not to pursue transition; and Individual #359, for whom inquiry had been made of the court, but the court indicated he could not be transitioned to the community). Examples of concerns included: ▪ For Individual #159, the final recommendation was not to refer due to her hospitalization, but no specifics were provided regarding why she could not be referred just because she currently was in the hospital. ▪ As discussed above, Individual #296's team did not recommend transition, but provided inadequate justification, and he did not have a guardian. ▪ For Individual #146, the final recommendation was not to refer her due to her lack of understanding. However, the team had not fully implemented the previous year's plan, did not include in this year's plans an individualized approach to determining her preferences or the methodology to do so, and in her Rights Assessment indicated she could not make programmatic decisions. As a result, it did not appear she would be able to make this decision on her own, and the team did not identify a way for them to get the best sense of her preferences quickly, and move forward with a decision. This was similar for Individual #77. ▪ For Individual #310, as noted above, the team made a referral, but it appeared to be based on a lack of understanding of what the community system could provide for an individual with pica. Teams generally were not having thorough discussions about community living options. Although Facility discipline members generally were making a specific recommendation independent of the individual and his/her guardian, problems continued with regard to teams documenting a well-supported justification for their decisions. The Facility remained out of compliance with this provision.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	Since the Monitoring Team's last onsite review, seven individuals had transitioned to the community. Three of these individuals' CLDPs were reviewed (i.e., Individual #55, Individual #61, and Individual #34). This represented 43% of the relevant CLDPs. Based on review of these CLDPs: ▪ Based on review of ISPA or other meeting documentation: o None of the three (0%) CLDPs were initiated within 14 calendar days of referral. o None of the three (0%) CLDPs included documentation (e.g., ISPAs or other document) to show that they were updated throughout the transition planning process. o None of the three (0%) CLDPs or other transition documentation included documentation to show that IDT members actively participated in the transition planning process (e.g., visited potential	Noncompliance

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		homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). For each of these three individuals, very little documentation was submitted to show team involvement in the process. ▪ None of the three (0%) CLDPs or other transition documentation included documentation to show that the Facility worked collaboratively with the LA. Although the LA attended the CLDP meetings, documentation did not clearly indicate what collaboration occurred, and ISPA documentation did not show ongoing collaboration with the LA. The Facility remained in noncompliance with this provision.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	a. The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. Since the last review, the Facility had made some efforts to include some more specific supports and services. However, none of the three CLDPs reviewed (0%) (i.e., those for Individual #61, Individual #55, and Individual #34) clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition by including documentation to show that all of the activities listed in the following six bullets occurred adequately and thoroughly as appropriate to meet individuals' needs. The following describes examples in which some of these activities occurred for some individuals, as well as example of where they should have occurred, but did not: ▪ <u>Training of community provider staff, including staff to be trained and level of training required</u>: One of the plans identified the need for training for community provider staff (i.e., Individual #55). Those that did not were Individual #34, and Individual #61. This had been improved by providing more information about what would be included in the training. However, the plans did not define which community provider staff needed to complete the training (e.g., day and residential staff). The one CLDP that included references to training did not identify what level of mastery of the information was required (e.g., demonstration of competence, etc.). When staff competency needs to be measured, the specific competency check-off forms or specific methodology to test competence should be identified. In addition, in some plans, it appeared that teams had decided not to include pre-move required training supports, because training had occurred when the individuals had done visits. This showed a misunderstanding of the need for the CLDPs to document necessary services and supports that met the individuals' needs, regardless of whether they had occurred yet or not. Such supports should be listed, and part of the pre-move monitoring should involve ensuring that they occurred, for example, to confirm that no new staff had come on board that required the training;	Noncompliance

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		▪ Collaboration with community clinicians (e.g., psychologists, PCP, SLP): None of the plans included collaboration, but all of them should have. As the Monitoring Team has repeated indicated, such collaboration is essential to ensure ongoing coordination of care. ▪ Assessment of settings by SSLC clinicians (e.g., OT/PT): For none of the individuals did this appear necessary; ▪ Collaboration between provider day and residential staff: No coordination was specified as needing to occur between current and future residential or day/vocational staff, and for these individuals, this would have been an important component. For none of the individuals did it appear the teams had even discussed this as a possible need; ▪ SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community): For none of the individuals were such supports included, and did it not appear the teams had even discussed this as a possible need; and ▪ Collaboration between Post-Move Monitor and Local Authority staff: The monitoring activities were identified in the CLDPs, including the role of the IDD Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. However, no action steps were designed to ensure that the Post-Move Monitor worked together with the Local Authority Service Coordinator to pass on important information or ensure monitoring continued to occur of pre- and post-move required supports. b. Three of the three CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. However, documentation was not included to show that the activities did indeed occur. The Facility remained out of compliance with this provision. Continuing problems were noted with regard to teams' definition and inclusion in CLDPs of comprehensive sets of specific steps that Facility staff would take to ensure smooth and safe transitions for the individuals moving to the community.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-	Evidence of Individual/LAR Participation • a. Based on review of three CLDPs, three (100%) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by	Substantial Compliance

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	making regarding the supports and services to be provided at the new setting.	signatures on CLDP. As a result, the Facility was found to be in substantial compliance with this provision.	
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	This requirement of the Settlement Agreement includes two components, including the timeliness of assessments (i.e., within 45 days of the individual leaving the Facility), and the comprehensive nature of the assessments. Although the Facility had made progress with regard to obtaining timely assessments and some improvement was seen with some assessments, the quality (i.e., comprehensiveness) of most of the assessments was lacking. More specifically: ▪ a. For none of the three CLDPs reviewed (0%), all necessary assessments were completed. For none of the individuals had the PSI, or IRRF been updated to ensure that their preferences and needs, particularly their needs related to risk, were sufficiently addressed. Other missing assessments included psychiatry for Individual #34, Individual #55, and Individual #61, and nutrition for Individual #61. ▪ b. For none of the three CLDPs reviewed (0%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. In addition to some assessments not being submitted at all, the speech assessment for Individual #61 was completed prior to the 45-day timeframe. ▪ c. For none of the three CLDPs reviewed (0%), all assessments were available to the Placement Coordinator/Transition Specialist and IDT prior to the final CLDP meeting. ▪ d. For none of the four CLDPs reviewed (0%), the assessments were of adequate quality. The following summarizes concerns and areas of some improvement: o Most of the assessment formats were not designed to provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have been particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility. o On a positive note, some assessments had begun to include more detail regarding the protections, treatments, and supports that individuals needed (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), and/or the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.). Although this remained a work in progress, it was positive that some disciplines were beginning to include more detail. As discussed in further detail with regard to Section T.1.e,	Noncompliance

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		of significant concern was the fact that these more detailed recommendations were not consistently being translated into necessary pre- and post-move required supports. o Although some improvement was seen, assessments did not consistently identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. For example, nursing assessments for individuals who had nursing care/health management plans at the Facility should include recommendations about their continuation and/or any modifications that need to be made to accommodate community settings that might not have nurses available at all times. Similarly, psychology/behavioral assessments should identify differences (e.g., environmental, staffing, training of staff on protective holds, etc.) that could impact the implementation of the PBSP in place at the Facility, and/or make recommendations about needed modifications. o In addition to specific issues related to transition, as is discussed in other sections of this report, a number of the underlying assessments were not of adequate quality. o Finally, as has been recommended in previous reports, a process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would result in a document that could be provided to community medical care providers that would facilitate the transition of this information. The following specific information is repeated here from Section M to provide additional insight in concerns related to assessments. Regarding the nursing documentation for individuals discharged/ transitioning to the community, a review of the nursing documentation and Nursing Discharge Assessment Summaries for four individuals including: Individual #313, Individual #318, Individual #87, and Individual #34 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would specifically guide the community staff in providing the needed nursing care to the individual. ▪ An adequate nursing assessment was conducted at the time of the discharge	

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		from the Facility and documented in the IPNs for none (0%) of the individuals. ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed. The Facility remained out of compliance with this provision of the Settlement Agreement. A focus on improving the quality of assessments is necessary.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	<u>Adequacy of Pre-Move and Post-Move Required Supports</u> The CLDPs reviewed included pre-move and post-move required supports. Since the last review, some progress had been made. Admissions and Placement Department and Transition Specialist staff appeared to be working with individuals' teams to expand the scope and definition of pre-move and post-move required supports. Additionally, efforts were underway to improve ISPs to more effectively describe individuals' needs for supports, and define how such supports were to be provided at the Facility. If done correctly, this should greatly assist teams when it is time to plan for an individual's transition to the community. However, to make use of these improvements, teams will need to use the ISPs more effectively when developing CLDPs. Overall, though, at the time of the current review, teams did not consistently identify all the pre-move and post-move required supports that the individual needed to transition safely and successfully to the community. This lack of comprehensive identification of supports made it difficult to ensure individuals' successful transitions, and for thorough and meaningful monitoring to occur prior to and after the individual's transition to the community. a. In none of the three CLDPs reviewed (0%), a comprehensive set of pre- and post-move required supports was identified in measurable/observable terms. The Monitoring Team has provided many examples of concerns in previous reports. The Facility's CLDPs continued to have missing supports. The following provides examples of CLDPs in which appropriate pre- and post-move required supports had been included for some individuals, as well as example of where they should have been, but were not: ▪ 1) <u>The list should be comprehensive and inclusive, demonstrated by</u>: o Sufficient attention should be paid to the individual's past history, and recent and current behavioral and psychiatric problems: ▪ As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move supports should define how the current methods for dealing with crises at the Facility should be modified in a community setting. For Individual #61, who had a PBSP for physical aggression, SIB, property destruction, and verbal aggression, the CLDP included no requirements for	Noncompliance

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		provider agency staff to have training or skills in psychological or physical management techniques, and there was no plan for what should happen if a behavioral crisis were to occur; and the same was true for Individual #55; and ▪ For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle. Such supports generally were not identified as pre-move required supports, such as involvement of community provider agency behavior analysts from the time of or before the transition were not included as supports, even when this appeared necessary (e.g., for Individual #55, or Individual #61, both of whom had a number of target behaviors, and were prescribed psychotropic medication). o All safety, medical, healthcare, therapeutic, risk, and supervision needs should be addressed: ▪ For individuals whose teams identify them as being at-risk, CLDPs should be of adequate clinical intensity to address the level of risk. Specifically, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. All three individuals had risks that were not sufficiently addressed in the CLDPs; ▪ For individuals who have specific health care indicators that require monitoring (e.g., seizures, weight, aspiration triggers, etc.), teams should include supports in the CLDPs to ensure that specific staff are responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff. Although for some of the health care indicators of the three individuals, supports had been included to measure them (e.g., blood pressure, diabetes, and weight), a number of such supports were missing. In addition, sometimes parameters for reporting issues to health care staff were present (e.g., for Individual #34, for whom blood pressure reading were to be taken,	

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		parameters were set for when staff needed to contact medical professionals), but sometimes they were missing (e.g., for Individual #34, for finger stick readings; or for Individual #55, for blood pressure readings, seizures, or weights); ▪ With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of clinicians. For some individuals there was some limited definition of the roles of clinicians, but for none of the individuals was this done comprehensively. For example, for Individual #61, the frequency of involvement, the qualifications of clinical staff, and/or their roles (i.e., beyond establishing contact) were not defined (e.g., psychology or psychiatry); for Individual #55, the need for a BCBA was identified, but beyond "monitoring the behavior plan and making changes as needed," the roles of the BCBA in reviewing data, training staff, working with day and residential programs, etc. were not defined, nor was the intensity of the supports (e.g., weekly, monthly, etc.), and it was unclear with what frequency she needed to see the psychiatrist; and for none of the individuals, the level or intensity of nursing supports needed was defined. ▪ In removing any support that the individual utilized at the Facility from the array of supports that will be provided in the community, teams should justify why the support is not needed in the community. For at least one of the individuals, supports provided at the Facility were removed/not included in the CLDPs, and adequate justification was missing (i.e., for Individual #34, a reinforcement program was substituted for a PBSP without any specific data or justification); and ▪ Direct support staffing ratios and requirements should be specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training	

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		requirements for staff, competencies or certifications needed, etc.). For none of the three individuals were staffing supports defined (i.e., Individual #34, Individual #61). ○ What was important to the individual should be captured in the list of pre-/post-move supports. The PSI was not one of the assessments updated for the CLDPs. However, Individual #34, Individual #55, and Individual #61 had lists of preferences as post-move required supports. These were all simply lists that stated that the individual would "continue to enjoy his/her preferred activities." Although this was a good start, the lists were not particularly measurable, and did not show integration throughout the CLDP, as appropriate, of the individual's preferences. ○ The list of supports should address thoroughly the individual's need/desire for employment, and/or other meaningful day activities. ▪ Particular attention needs to be given to adequately defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. Supports that need to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) should included as part of the day/vocational component. This was missing from all three plans (e.g., for Individual #34, the only related support was that she would attend the provider's day habilitation program; Individual #61 was to attend school, but during non-school times, the only reference was to attending the provider's day program; and for Individual #55, the only support was that she would attend a specific day program). ○ Positive reinforcement, incentives, and/or other motivating components to an individual's success should be included in the list of pre-/post-move supports. Other than global supports related to involving individuals in preferred leisure activities, supports that integrated individualized positive reinforcement of incentives were missing from two of the plans reviewed. The only plan that	

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		included reference to this was for Individual #34. ○ There should be pre-/post-move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. For Individual #55, the only reference was to providing copies of the SAPs, not their implementation. For the other individuals, no reference was made at all to the SAPs in the CLDPs. ○ There should be pre-/post-move supports for the provider's implementation of supports, including, for example, the BSP, PNMP, dining plan, medical procedures, nursing care plans/IHCPs, therapy and dietary plans, and community provider staff would be required to continue: ▪ As appropriate, teams should identify as post-move supports the implementation of current plans (e.g., nursing care plans, health management plans, PNMPs, diets, exercise programs, etc.). As necessary, modifications should be made to the methodology for providing these supports, with the end result being the individual's need for the support being met. Based on review of the three plans, generally PBSPs were referenced as needing to be implemented, but other plans, such as nursing care/IHCPs often were not (e.g., Individual #34, Individual #61, and Individual #55), and it was unclear if all components of PNMPs had been translated into supports, or clear justification provided for not including them. For individuals prescribed psychotropic medication, except for lab work, no plans were included for monitoring for side effects (i.e., all three individuals); ▪ CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community; ○ All recommendations from assessments should be included, or if not, a rationale should be provided. For many recommendations for all three individuals, corresponding pre- or post-move required supports were included. However, for each of the three individuals, there were recommendations that were not included, and for which adequate justification had not been provided for not including them. ▪ 2) <u>The wording of every pre-/post-move support should be in measurable, and observable terms</u>: Most supports were measurable. However, for each of the four individuals, supports were included that were not measurable (e.g., lists of	

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		preferences, "maintain contact" with mother, "encourage to eat slowly"). ▪ 3) <u>Every pre-/post-move support should include a description of what the PMM should look for when doing post-move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur</u>: For each support, evidence was listed. However, as noted above, sometimes without a frequency listed, it was difficult to tell what evidence was expected for which supports. In summary, since the last review, some improvement was noted with regard to the comprehensiveness of pre-move and post-move required supports. Although the CLDPs continued to be missing a number of necessary protections, services, and supports, it was positive that the Facility had focused on improving the quality and comprehensiveness of the CLDPs, particularly the pre- and post-move required supports. <u>Essential Supports in Place on the Day of the Move</u> As noted in previous reports, the Facility was having the Post-Move Monitors conduct a pre-move site visit designed specifically to determine if the pre-move supports were in place. Based on review of pre-move monitoring for four individuals (i.e., Individual #34, Individual #61, Individual #55, and Individual #323): ▪ b. For the four of four individuals (100%), a pre-move site review was conducted by the Facility. ▪ c. Of these four individuals' pre-move site reviews, four (100%) were done timely and completely. ▪ d. Of these four individuals' pre-move site reviews, none (0%) indicated that all of the essential supports were in place prior to the individual's move. Problems included a lack of evidence showing that the pre-move required supports were actually in place. Either no evidence was specifically listed (i.e., just the language from the CLDP evidence column was repeated with no detail about what actually was found), or statements indicated that pre-move supports would be in place, with no confirmation that they were. A couple of examples include: o For Individual #61, for a number of supports, the Post-Move Monitor stated: "will be provided… by the time [Individual #61] moves," but there was no confirmation that the supports were in place at the time of the move. o For Individual #55, for a number of supports the Post-Move Monitor indicated that training was scheduled or that items would be provided to the community provider, but these had not yet occurred, and there was no confirmation that the supports had been addressed at the time of the move. Individual #55 also had not been accepted yet at the day program, but it did not appear this was brought back to the team. ▪ e. The following indicator was not completed, because the Monitoring Team did	

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		not observe any pre-review site visits: For___ of __ (%) pre-move site visits observed by the Monitoring Team (if any), the pre-move site visit was conducted thoroughly. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Documentation with regard to confirmation of pre-move required supports was not sufficient to show the supports were in place. In addition, although some improvement had occurred with the delineation of the pre- and post-move required supports in individuals' CLDPs, a number of protections, supports, and services continued to be missing from the CLDPs.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	a. There was not a written policy or written process for quality assurance to ensure the: a) development; and b) implementation of CLDPs. As discussed with regard to Section T.1.b, at the time of the review, the Facility did not have a local policy on the most integrated setting. When such a policy is developed, it should define the specific procedures the Facility will use to conduct quality assurance activities related to CLDP, and the Facility's implementation of them. b. Data were not collected consistently. The Facility submitted just one completed monitoring tool for a CLDP. In addition, the data were not being collected reliably, and it was unclear that the data were valid. The tool being used did not define the standards used, and did not result in valid findings. In addition, inter-rater reliability had not been established between the QA Department and the Admissions Placement Department. However, based on the list of topics discussed at meetings with the QA Department, it appeared the Admissions Placement Coordinator reported was working with the QA Department on establishing inter-rater reliability. c. Based on a list of meeting dates and agenda items, the QA Department and Admissions Placement Department had been meeting monthly to review data, but minutes were not maintained. The Facility submitted a brief listing of topics discussed, which appeared to relate to inter-rater reliability between reviewers. Until valid data are available, the following indicators cannot be assessed in any meaningful way: Data **were/were not** reviewed, summarized, and analyzed. Actions **were/were not** taken as a result of analysis of the data. The data **were/were not** included in the Facility's QA program. However, based on the review of the agenda items for the monthly meetings between the QA and Admissions Placement Departments, use of the data collected to identify issues that required correction did not appear to be part of the discussion.	Noncompliance

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		d. The following was not applicable, because no one had returned to the Facility: For __ of the ___ individual (__%) who returned to the Facility after a failed community placement, an adequate review **was/was not** conducted to determine if changes in the referral and transition planning processes at the Facility should be made. Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for __ (%). e. One individual (i.e., Individual #47) that transitioned to the community passed away since the last onsite review. Of these, there was an adequate review conducted to determine if changes in the referral and transition planning processes at the Facility should be made for none (0%) of the cases. Of these reviews, actions related to the transition planning or implementation process were recommended in no case. As a result, the following could not be assessed: Of these ___ cases, actions were implemented for ___ (%). The team for Individual #47 did not conduct a critical review of the transition planning or implementation processes following his death. The team, including members of the CCSSLC team and the community provider team, simply concluded that Individual #47 did not have a history of running away, and, the event that caused his death involved him running away from staff with no warning, and running onto a freeway, where a car hit and killed him. Based on the Monitoring Team's review of the CLDP and related assessments, the following concerns were noted, but the team had not reviewed and/or addressed them: ▪ The discharge summary that the Behavior Health Specialist completed indicated: "[Individual #47] was transferred to Corpus Christi State School and lived on Angelfish. He then transferred to Pompano and from Pompano to Sailfish, in 2009, however, due to increased aggressive incidents due to an unfamiliar environment; he was transferred back to Pompano." Although this history showed he had difficulties with transition, the team did not build in any specific supports into his CLDP to address this issue. In fact, the team discontinued his Positive Behavior Support Plan due to no aggressive episodes in a year and two months, and did not include any behavior supports in his CLDP. Given the change in environments and his history of having increased behavioral episodes and confusion when his environment changes, the team should have planned for some potential changes in his behavior, but did not. Moreover, during the review after his unfortunate death, the team did not identify this oversight. ▪ The Behavioral Health Services discharge summary went on to state: "[Individual #47's] memory problems are severe to the point that he gets lost while on [sic] the home." The QIDP Discharge Summary similarly stated: "he at times misplaces items and/or finds himself lost on campus." He had a skill acquisition program related to teaching him what to do if he became lost in the	

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		community. His vocational assessment indicated: "[Individual #47] gets lost coming to work having no sense of direction at times. [Individual #47] has to be redirected by staff informing him his [sic] work location." Based on review of the CLDP, the only support to address memory problems read: "A picture will be taken of [Individual #47] and his house and placed on his door at the group home to assist him with identifying his room." Otherwise, no pre-move or post-move required supports were included that clearly addressed Individual #47's issues related to memory, getting lost, or issues he might experience on community outings. For example, the IDT had identified no specific staffing supports (i.e., the only support listed was "requires 24 hour awake staff"). As the Monitoring Team has repeatedly stated, in specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). Given his confusion/memory issues and the team's identification that he could get lost in the community, the CLDP should have specifically defined the level of staffing he needed in the community versus at his group home. ▪ The Behavioral Health Services discharge summary also stated that he had a seizure disorder that "may potentially contribute to behavior," and that his record: "indicated that he experienced auditory hallucinations in which the devil would command him to harm himself…" Unfortunately, no psychiatric or medical discharge assessments were included in the packet the Facility provided to the Monitoring Team. As a result, it was unclear whether or not the IDT that developed the CLDP had updated information related to his neurological and psychiatric status. This would have been important to determine whether or not hallucinations and/or seizures were currently an issue, what the hallucinations consisted of (e.g., how did the hallucinations tell him to harm himself), and to identify the supports that were needed, including staffing, data collection regarding symptoms, as well as medical and psychiatric supports. f. It was unclear whether or not the Facility provided a full list of potentially negative outcomes, because the Facility labeled the list it submitted as "Any tracking data for individuals who have transitioned to community since Monitoring Team's last visit including hospitalizations, ER visits, and 911 calls." This was not responsive to the Monitoring Team's request. The information the Facility provided was not sufficient to determine the following: Over the past year, of the ____ individuals transitioned, ____	

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		(___%) experienced one or more potentially negative outcomes since transition. Of the ____ individuals not previously discussed, there was an adequate review conducted for ___ (___%) of the cases to determine if changes in the referral and transition planning processes at the Facility should be made. Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for ___ (%). Based on the information provided, however, there was one death, and one hospitalization for a broken leg resulting from an accident at the day program. Based on interview, the individual that broke his leg spent time in a rehabilitation facility as well. Based on other documents provided as well as interview, other potentially negative outcomes had occurred, such as Individual #94, who had an unauthorized departure and was missing for most of one day, and the community provider had not notified the Facility; and Individual #55, who also had an unauthorized departure that resulted in police contact and an ER visit to rule out a panic attack. Since the Monitoring Team's last review, the Facility's progress in this area remained essentially unchanged. The Facility should increase and improve its monitoring activities for CLDPs, including modifying, as appropriate, the monitoring tool to improve the guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability. In addition, as valid monitoring results are obtained, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. It is also essential that the Facility conduct critical reviews of the CLDP development and implementation processes for individuals that experience potentially negative outcomes.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the	<u>Facility Efforts</u> a. The Facility maintained a list of individuals whose referrals had exceeded 180 days, and the obstacles teams had identified. Although the Facility had a system to collect information about obstacles to transition, it was not adequate, because it only collected information about obstacles after the individual's referral had exceeded 180 days. Reported obstacles should include both issues that prevent transition as well as "compromises" to meeting the individual's needs and/or preferences as outlined by the IDT. Examples of compromises would include the individual "settles" for a day habilitation program because the vocational program that the team recommended or that the individual preferred was not available in the part of the state in which the individual/guardian wanted to live; or the individual moved to an area of the state that was not the original preference because clinical services were not available close to	Noncompliance

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	Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	family or in a part of the state that the individual preferred. It will be important as a system for collection of obstacles to transition is finalized to include these types of obstacles. This is essential to ensure that State Office has information to identify areas in which community capacity should be expanded. b. The Facility did not have an annual narrative that showed it had: a) conducted a comprehensive assessment of obstacles; and b) developed and implemented appropriate actions to address and overcome these obstacles on the local level within the authority of and resources available to the Facility. Some examples of problems included: ▪ As noted above, it was not clear that teams were thoroughly and/or correctly identifying obstacles to referral or transition. As a result, the data on which the report was based was not considered valid. ▪ One of the most significant obstacles to referral was identified as Individual Choice – Lack of understanding of community living options. However, the report did not set forth an aggressive plan to ensure individuals were educated about their options. ▪ Table 3 that broke down the reasons for LAR Choice clearly did not provide information for all 77 LARs that were reluctant. This illustrated the concern that the Monitoring Team has consistently raised that teams were not identifying the specific reasons for LAR reluctance. Until this is done, it will be difficult to meaningful address this obstacle. ▪ With regard to community supports needed for individuals with complex medical and/or behavioral/psychiatric needs, the Facility made no recommendations to State Office regarding specific supports that are missing from the community system that would be necessary for individuals from CCSSLC to transition to the community. CCSSLC's report provided no analysis of the capabilities or capacity of the local providers for these groups of individuals. <u>Annual Narrative by DADS State Office</u> c. The State did not present an annual narrative that showed it had: a) conducted an analysis of the Facilities' data; b) taken appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities; and c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature. DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/13 from all 13 Facilities. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: ▪ The statewide report listed the six obstacles to referral categories and 12	

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		obstacles to transition categories used in FY13. ▪ DADS included a list of 14 initiatives it was continuing to support. ▪ The report included attachments with each of the Facilities' annual reports. ▪ The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the Monitoring Teams' reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • Transition Data: In the report, the State Office provided overall data related to transition of individuals from SSLCs, and the overall census from fiscal year to fiscal year. However, the data was fairly meaningless, because the data was not broken down sufficiently or analyzed. For example, although Facility censuses had decreased over the years, data was missing and no analysis was provided regarding how many individuals had died, how many admissions occurred, the numbers of individuals that died shortly after transition to the community, the numbers of individuals transferred to other large facilities, etc. • Transition obstacles data: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. As a result, the validity of the data provided in the report was questionable. Further, it would be useful to formalize the process to identify obstacles far ahead of the 180-day goal (i.e., not wait until 180 days have passed before identifying and documenting obstacles). o State Office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, State Office staff said that their data system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The Monitoring Team believes that this information should be included in the report. • DADS' strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were	

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		not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the Facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. o During recent discussion with State Office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies (and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition). • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). o The Monitoring Team was unable to determine this because there was no information in the report addressing it. The Facility remained in noncompliance with this provision.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for five individuals (i.e., Individual #34, Individual #61, Individual #55, Individual #323, and Individual #112). This sample represented five (56%) of the nine individuals for whom the CCSSLC Post-Move Monitor needed to complete reviews since the Monitoring Team's last review. For the five individuals, 12 reviews should have been completed during this time period. Of the 12 required visits, all (100%) had been documented as having been completed on time. <u>Visits to All Sites</u> The Facility continued to ensure that visits had been made to both the residential and day sites of the individuals, and that this was documented in the reports. This was largely determined by reading the narratives of the post-move monitoring reports. <u>Content of Checklists</u> Based on a review of the post-move monitoring reports five individuals, one of five individuals' reports (20%) (i.e., those for Individual #34) were completed thoroughly. Although it was positive that the Post-Move Monitor had continued to document the	Noncompliance

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	support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	evidence to support her conclusions about the presence or not of pre- and post-move supports, the following concerns were noted: ▪ For a number of individuals, observations during mealtimes were required according to the CLDP, but the narrative did not describe that observations were completed. ▪ For Individual #323 the Post-Move Monitor did not confirm that the "psychologist" was a BCBA as required by the support. ▪ Sometimes, the Post-Move Monitor relied on interview when documentation was required as evidence (e.g., for Individual #112, the flu shot). ▪ Sometimes the Post-Move Monitor had checked "No," when it appeared "N/A" was more appropriate, because a support was not yet due. These discrepancies were limited to a few supports, and might only become problematic if aggregate data were used to assess post-transition compliance with CLDPs, which the Facility was not currently doing. On a positive note: ▪ All pre-move and post-move supports were reviewed. ▪ Generally, when full evidence was provided, it appeared that the Post-Move Monitor had correctly rated the pre-move and post-move supports as being present or not. <u>Use of Facility's Best Efforts to Ensure Supports Are Implemented</u> The primary reasons for conducting post-move monitoring are to identify if the protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The following summarizes the findings of the review of post-move monitoring documentation: ▪ Of the five individuals reviewed, five of them had needs identified for which follow-up was necessary to ensure supports were implemented. ▪ Of the five individuals for whom follow-up was indicated, documentation was present to show that for one (20%), sufficient follow-up had occurred. Concerns included: o For Individual #34, although an action plan was included related to a number of follow-up activities the PMM was going to conduct, no documentation was provided to show that the follow-up actually occurred. o For Individual #55, the narrative of the 45-day report indicated the Post-Move Monitor would follow-up with the team regarding the need for a mat by her bed due to seizures. However, there was no indication of whether or not this occurred. o For Individual #323, the community psychologist appeared to have discontinued Individual #323's PBSP, but it did not appear that the IDT	

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		at CCSSLC had reviewed this decision. o For Individual #112, the team was supposed to meet to discuss children in the group home, due to past issues, but documentation was not submitted to show this had occurred. In addition, Individual #112 was about to lose his job at CCSSLC, and no plans were in place for him to obtain a new job. It was unclear what actions the Facility was taking to ensure the provider obtained an appropriate job for Individual #112. The Facility was found to be in noncompliance with this provision. Although the post-move monitoring reports generally were thorough, some problems were identified that need to be addressed. During the last review, the Facility was found to be in substantial compliance, and at that time, improvement was seen in at least one IDT's involvement with the follow-up necessary to address the results of post-move monitoring visits. However, during this review, concerns were again noted with regard to follow-up activities, and teams' involvement. In addition, as a note of caution, as identified above, CLDPs were still missing many necessary supports. As improvements occur with the CLDPs, post-move monitoring activities and related follow-up will necessarily become more extensive.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	During the week of the onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on a post-move monitoring visit for Individual #34. The Monitoring Team appreciates the Post-Move Monitor finalizing the report from the visit, because this provided the opportunity to compare the observations of the visit with the written report. Based on observations, the Post-Move Monitor thoroughly reviewed each support. She asked many good questions, conducted observations, and reviewed relevant documentation. During the course of the review, the Post-Move Monitor identified some issues related to supports included in the post-move list on the CLDP. The Post-Move Monitor worked professionally with the provider staff to discuss these issues and potential solutions. For example, some follow-up was needed with the CCSSLC team and the LA staff regarding a support related to a reinforcement program, and the community provider had not yet completed breast exams for Individual #34, or scheduled some necessary doctor's appointments. The Post-Move Monitor documented her findings, including relevant evidence that she reviewed with few exceptions (e.g., for the support related to administration of medication, although the Post-Move Monitor reviewed the MAR, this was not mentioned in the list of evidence in the report), as well as follow-up activities in which she had engaged.	Substantial Compliance

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		Due to the thorough and accurate post-move monitoring observed, the Facility has been found in substantial compliance with this provision. As has been discussed, maintaining substantial compliance will require the Post-Move Monitor to keep pace with the expanded responsibilities for monitoring that will occur once CLDPs are improved.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held	The parties had agreed that in addition to the categories listed in the Settlement Agreement, other circumstances resulting in an individual moving from a SSLC might fall under the category of "alternate discharges." One of these reasons was an individual transferring to another SSLC. Since the last review, one individual was considered to have an "alternate discharge," because he had been placed at the Facility for respite (i.e., Individual #115). Based on a review of the discharge summary completed for Individual #115, it contained the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. They included a summary of the individual's developmental, behavioral, social, health, and nutritional status. However, in some cases, this summary did not "accurately describe the individual, including his/her strengths, needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. In addition, the discharge plan did not appear to meet the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of	Noncompliance

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	during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	the requirements of the CMS-required discharge planning process is discussed below: ▪ **If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause:** Based on the information provided, in one out of one records reviewed (100%), good cause was identified in the discharge summaries (i.e., after temporary respite, Individual #115 was returning to the community provider from who he previously received supports). ▪ **The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies):** Based on the information provided, for one out of one individuals (100%), reasonable time was given to prepare. ▪ **At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status:** Although the final summary included each of these components, for none of the one individual (0%) was the information adequate. Concerns included: o Individual #115 was placed with CCSSLC for short-term respite in order for issues he was experiencing in a community setting to be addressed. Presumably, these related to behavioral and/or psychiatric issues. However, the summaries included no indication of the specific interventions that were developed to assist Individual #115 to return to a more integrated community setting. o Generally, little information was provided about the supports the individual had received at CCSSLC. For example, only the nutritional and medical summaries discussed current treatment. Remarkably, the behavioral section did not. In addition, little analysis was provided regarding what supports had assisted the individual versus those that had not been effective to assist the receiving facility to develop an appropriate treatment plan. For example, the individual was described as having significant behavioral issues. However, the behavioral summary and the psychiatric summary were very general, and did not provide the receiving facility specific information about the individual's current status or which interventions were most effective. ▪ **With the consent of the individual, parents (if the client is a minor) or legal guardian, provides a copy to authorized persons and agencies:** For none of the one individual (0%), CCSSLC provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving Facility. ▪ **The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment:** Based on the narratives	

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		provided in the Referrals and/or Necessary Services Required in New Environment section, the IDT for none of the one individual (0%) adequately described the key supports that the individual would need in his new setting. As noted above, Individual #115 had been placed temporarily at CCSSLC, a more restrictive setting than the community provider that had been supporting him, for the specific reason of developing supports that could assist him to return to the most integrated setting. The discharge plan did not provide a clear set of supports that the community provider should offer Individual #115 to prevent the need for more restrictive living environment, and help him to be successful in the community. The Facility was not in compliance with this provision. This was due to the fact that it did not meet the CMS requirements for transition/discharge planning.	

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section U; o In response to request for any State or Facility policies, procedures and/or other documents regarding consent and/or the identification of Legally Authorized Representatives (LARs), the statement that no new policies were issued; o QA/QI Quarterly Section Review: Section U – Consent, August to October 2013, and November 2013 to January 2014; o In response to request for: "Any instruments or processes used to determine functional capacity, and any instruments or processes used to prioritize the needs of the individuals," the response: "No Evidence For File;" o CCSSLC Guardianship Priority List, undated; o List of individuals for whom a LAR or advocate was obtained; o List of attorneys sent upon request to those interested in pursuing guardianship; o Volunteer opportunities flyer; o Letter sent to local college regarding advertising for volunteer opportunities on listserv; o Provider Fair flyer for event held 12/4/13; o Holiday Program flyer for event held 12/19/13; o Self-Assessment for Section U; o Provision Action Information for Section U; and o Action Plans for Section U. ▪ **Interviews with**: o Karen Forrester, Human Rights Officer (HRO).
	Facility Self-Assessment: The parties agreed the Monitoring Team would conduct a limited review of Section U (i.e., updates only). Therefore, the Facility Self-Assessment was not assessed.
	Summary of Monitor's Assessment: As has been stated in previous reports, until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires. During this most recent review, Facility staff indicated that State Office had issued a draft Individual Rights Assessment that included questions related to an individual's capacity to make decisions. Since the onsite review, the Monitors have jointly provided comments to State Office on the draft Individual Rights Assessment. The Facility continued to pursue some alternatives to guardianship, but this was an area in which more work was needed. For example, teams had identified approximately 13 individuals that would benefit from an advocate, and efforts continued to identify volunteer advocates. The Self-Advocacy Group engaged in activities that provided opportunities for participants to learn about their rights. As noted in past reports, CCSSLC continued to make efforts to identify potential guardianship resources.

	For example, a brochure had been developed and was being distributed in various forums, a relationship with a local university resulted in posting of volunteer opportunities on a listserv, and information about the need for volunteers to act as advocates or guardians was distributed at a booth at the Provider Fair. So far, limited, if any, resources for guardians had been identified. It will be essential that adequate resources be identified to address this need.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on interviews with staff and review of the Presentation Book and other documents, the following are updates regarding the steps the Facility had taken to move towards compliance with this provision: ▪ In the past several reports, it was noted that DADS State Office reportedly was developing a policy on consent to supplement the one it had issued on guardianship. This was essential, because until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires. During this most recent review, Facility staff indicated that State Office had issued a draft Individual Rights Assessment that included questions related to an individual's capacity to make decisions. Since the onsite review, the Monitors jointly provided comments to State Office on the draft Individual Rights Assessment. ▪ Because the Facility recognized that more work was needed to identify individuals' functional decision-making capacity, further work was not done on the guardianship priority list, except to update it by removing individuals that were no longer at the Facility, or who had guardians. ▪ CCSSLC continued working on some alternatives to guardianship and/or resources to assist individuals in making their own decisions. For example, the following valuable activities were ongoing: o One such support is the assignment of an advocate. Teams at CCSSLC continued to discuss this as an option. As noted in the last report, the HRO had drafted and the Guardianship Committee had reviewed and approved a mechanism to track individuals whose teams had recommended an advocate. Based on interview, generally these were individuals that did not have anyone from outside the Facility to advocate on their behalf. At the time of the review, a list of approximately 13 individuals had been generated, dated 1/31/14. As discussed in further detail with regard to Section U.2, the HRO was	Noncompliance

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		continuing to engage in activities that might be helpful in identifying volunteer advocates for individuals needing them. o The HRO was an advisor to the Self-Advocacy Group. As illustrated during the week of the review when the self-advocates actively participated in a game of Rights Bingo, the Self-Advocacy Group engaged in activities in which participants had opportunities to learn more about their rights and responsibilities. Such efforts to provide education should assist some individuals to expand their decision-making capacity. As discussed in previous reports, it will be important to expand these efforts, and for teams to individualize them. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures; expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). As noted above, the Facility remained out of compliance with this component of the Settlement Agreement.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. Based on interviews with staff and review of the Presentation Book and other documents, the following are updates regarding the steps the Facility had taken to move towards compliance with this provision: ▪ Working in conjunction with a member of the Active Treatment Department, the HRO developed a volunteer advocacy/guardianship brochure, and it was being distributed as opportunities were identified. For example, Community Relations staff took them to job fairs, a local store made copies of them available, and they were available at the Provider Fair. ▪ Volunteer opportunities were now listed on a local university's listserv. Students in certain degree programs at the university were required to complete volunteer hours. ▪ A guardianship attorney list was included with the pre-ISP mailing, which	Noncompliance

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	organizations, and other entities seeking to advance the rights of persons with disabilities.	regularly included information about guardianship. ▪ The Self-Advocacy Group and HRO had a booth at the Provider Fair at which information about volunteer opportunities was available, including guardianship information. ▪ The Guardianship Committee continued to meet, and efforts were being made to expand participation to include more community members. As noted above, the Facility remained out of compliance with this provision.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Persons Responsible for Management of Records; o Description of Quality Assurance Procedures, undated; o Minimum Documents included in Master Record, dated 1/21/13; o Active Record Order and Guidelines, dated 4/5/13; o Individual Notebook and Guidelines, revised 9/23/13; o Quality Assurance Checklists completed for last 10 records reviewed by Facility staff; o Sections V, F, and S Corrective Action Plan, implemented 10/3/13; o List of all new and revised policies implemented since the Monitoring Team's last review; o Emails provided at Section V meeting, various dates; o For the last three months, trending reports for Section V reviewed at monthly QA meetings with Records Department staff; and o Presentation Book for Section V. ▪ **Interviews with**: o Cynthia Velasquez, Director for Quality Assurance; o Blanca Goans, Administrative Programs Specialist; and o Desi Onovughe, Medical Records Coordinator.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section V of the Settlement Agreement, the Facility found that it was in substantial compliance with Section V.2. This was not consistent with the Monitoring Team's findings. In its Self-Assessment, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. A number of the indicators included in the Facility Self-Assessment for Section V had merit. However, as discussed with regard to Section V.3, the Facility had developed instructions for the audit tool, but the criteria used called into question the validity of the results. The Facility was in the process of reestablishing inter-rater reliability between the Records Department and QA Department staff responsible for auditing. In addition, some basic data descriptions were now available, and the Facility recognized that the next step was further in-depth analysis of this information. Overall, the Facility had demonstrated that it was beginning to incorporate some of the data it had collected into its self-assessment process. Efforts to ensure the validity of the data will be important next steps. In addition, it will be important to use the data to identify areas in which focused attention is needed.
	Summary of Monitor's Assessment: CCSSLC continued to maintain Active Records, as well as Individual Notebooks, and Master Records. The quality of the records was an area still in need of attention. Since the

	last review, the Unified Records Coordinator position was vacated, so the Facility was rebuilding its system related to conducting regular record reviews. The Facility recognized that next steps included analyzing the data, and developing and implementing plans to correct any issues identified. Since the last review, the Facility had developed and implemented an I-Learn course on Policy Creation, Maintenance, and Training. It provided good information in an interesting format, and included some quizzes to ensure staff's understanding. At the time of the last review, a method was being developed to accurately track staff's training on policies. At the time of this most recent review, the Competency Training Department had a process to for tracking the completion of training, and was able to send reminders to staff who had not yet completed the training. The Administrative Programs Specialist also assisted with training follow-up, and reported the training status to the QA/QI Council. However, it remained unclear whether staff were trained on State Office policies, and whether local policies had been developed or updated to correspond with State Office policies.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Based on documentation, as well as staff report, all individuals had Active Records, Individual Notebooks, and Master Records. File Clerks continued to have responsibility for maintaining the Active Records, for the most part. However, some exceptions had been made to this. Some of these distinctions were described in previous reports. As reported previously, Residential Coordinators were responsible for maintaining the notebooks. The file clerks removed data related to individuals skill plans and PBSPs on a monthly basis, and filed it in the active records. As reported in the Monitoring Team's previous reports, the Medical Records Coordinator had completed the conversion of the Master Records. In addition, information that could be stored offsite had been prepared and sent to a secure warehouse from which retrieval was readily available should there be a need for the records. Similar to the previous review, from the Monitoring Team's limited review of records while on site, it was noted that very few documents were missing from the records. As noted in the previous reports, one of the mechanisms that seemed to have had a positive effect was the implementation of the Active Records Document log. It identified typical items to be filed for each discipline. The log allowed a record to be maintained of when departments submitted documents, and when they were filed. This was an electronic system, which allowed functions such as auto-populating fields, and linking references to documents to their electronic version. It also allowed tracking and	Noncompliance

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		trending to be completed more easily. As noted in the Monitoring Team's previous reports, the Facility had an Active Record Check out procedure. This procedure went into effect any time an individual's active record needed to leave the unit, for example, for medical appointments or an ISP meeting. This policy addressed an essential component of maintaining control over the security of the records. As the Facility recognized, the next step towards compliance with this provision was using the information from its audits to identify and address issues related to the quality of the records. As discussed while the Monitoring Team was on site, Appendix D requirements are a key component of substantial compliance with this provision. As is discussed in further detail with regard to Section V.3, the Facility had data that showed where some of the quality issues were. During the Monitoring Team's previous onsite review, the Unified Records Coordinator made impressive changes to spreadsheet used to collect audit data. These modifications allowed the aggregation of this data across disciplines as well as residential sites. Shortly before the most recent review, the Unified Records Coordinator position became vacant. It will be important over the coming months to use data from record audits to identify trends, and take actions to correct them. Since the last review, the Facility had made efforts to learn about I=Learn courses that other Facilities were using. Such a resource would serve as a good refresher for staff on their responsibilities regarding records. Since the last review, limited progress had been made in this area. At the time of the review, the Facility remained out of compliance with this provision.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Since the last review, the Facility had developed and implemented an I-Learn course on Policy Creation, Maintenance, and Training. It provided good information in an interesting format, and included some quizzes to ensure staff's understanding. As noted in the Monitoring Team's last three reports, the Facility had developed a system to track draft policies through to finalization. The QA/QI Council was responsible for approving policies, and based on proposals from the authors of policies, decisions were made at QA/QI Council about who needed to be trained, who would provide the training, and the curriculum used. At the time of the review, based on the crosswalk the Facility provided, the Facility was awaiting policies from State Office for three of the 20 Sections of the Settlement Agreement. These included a final policy for Section G on Integrated Clinical Services, a	Noncompliance

#	Provision	Assessment of Status	Compliance
		final policy for Section H on Minimum Common Elements of Clinical Care, and a second policy for Section U to address the remaining components of the Settlement Agreement requirements related to consent. The Facility had developed a policy related to Integrated Clinical Services. This resulted in the Facility having policies in place for 18 out of 20 Sections of the Settlement Agreement (90%). The quality of these policies, any concerns regarding their content, and the status of their implementation are addressed in the various sections of this report. As noted in previous reports, the Facility had developed a process to review and revise policies, and determine which staff required training on policies, what level of training was required, and to track completion of the training. Since the last review, the Facility had made some progress in ensuring that local procedures had been developed to operationalize State Office policies, as well as to complete training for staff on the policies and procedures. However, the following concerns were noted: ▪ The Facility was asked to provide: "As available, for State Office policies, percent of staff trained…" No documentation was provided. ▪ In addition, the crosswalk provided did not show that local policies were up-to-date. Many dated back to 2010, and it was difficult to determine whether or not applicable policies had been updated to reflect current State Office policies. On a positive note, based on a review of a sample of data the Facility provided for recently issued policies and procedures, training had been consistently documented for required staff, and when training was outstanding, correspondence was sent to relevant supervisors to request that training occur. The Facility maintained a Finalized Policy Tracking Log. In summary, the Facility had a number of components of a working system for policy and procedure development and the completion of related training. Specifically, the Facility had implemented a process to review and adopt State Office policies, but it was unclear whether or not corresponding Facility procedures had been developed or updated to operationalize the State Office policies as well as other procedures necessary for consistent implementation of the requirements of the Settlement Agreement. The QA/QI Council provided a reasonable mechanism to ensure that an interdisciplinary group was available to critically review policies and procedures. As noted above, the quality or completeness of the policies, as well as the full implementation of the policies/procedures are not addressed with regard to Section V.2, but rather in other sections of this report. The QA/QI Council also made decisions about training on policies and procedures. With the involvement of CTD, the Facility had a working system to track staff's completion of the related training. However, no information was provided in response to a request for information about the status of training on State Office policy. The Facility remained in noncompliance with this provision.	

#	Provision	Assessment of Status	Compliance
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Due to the vacancy with the Unified Records Coordinator position some changes had occurred. The following summarizes the current status: ▪ The Unified Records Coordinator had been conducting five record reviews per month, but while the position was being filled, the Medical Records Coordinator was helping with the records audits. The PCM had assisted by completing a record review with the Medical Records Coordinator. ▪ To conduct the audits, the monitors were completing the Active Record Order Guidelines Audit Tool, and then the information collected was used to complete the monitoring tool entitled "Settlement Agreement Cross Referenced with ICF/MR Standards – Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4." ▪ Inter-rater reliability was in the process of being established. ▪ In the past, issues identified through the monitoring process with regard to individual records were addressed with the specific File Clerks. Individualized training or technical assistance was provided. In addition, Audit Trackers were sent to disciplines heads requesting corrections, if other departments were involved. The discipline heads were responsible to document actions taken. However, at the time of the Monitoring Team's onsite review, audits were not yet regularly being completed. ▪ While the Monitoring Team was on site for the last review, the Unified Records Coordinator modified the spreadsheet used to collect data on the audits. With these modifications, the very specific information collected about each record reviewed could be aggregated. This should significantly assist in trending the data and identifying issues that specific disciplines or residences might need to address, or for which the Facility might need to develop and implement more systemic actions. The Quality Assurance Director had taken over responsibility for conducting trend analyses. ▪ A CAP had been developed to address missing assessments in the records. In the past, QIDPs were responsible for collecting and submitting assessments. The CAP involved removing them from the process, and having disciplines submit assessments directly to file clerks. This CAP had been completed. ▪ As discussed in the last report, the Facility modified the standards it used for assessing the quality components of the records related to Appendix D of the Settlement Agreement. The Facility was encouraged to review these to ensure that they are sensitive enough to pick up potential issues, and it appeared some changes had been made. However, as the Monitoring Team understood it, each section of the record would be assessed separately (e.g., IPNs, observation notes, assessments, etc.), and if discrepancies (e.g., legibility, missing signatures, etc.) were found, then the section was marked as noncompliant. Then, if six sections within the same record were found to be noncompliant, the record would be	Noncompliance

#	Provision	Assessment of Status	Compliance
		counted as noncompliant for that particular qualitative component. This appeared to allow for too much variability in quality to provide valid results. ▪ The Facility had taken some initial steps in the analysis process. Specifically, the PCM had completed summary reports in which the data was described in more detail. This information could be used to conduct an in-depth analysis to try to answer the question "why." The Facility recognized that this was the next step in the process. Although the Facility continued to complete some of the tasks that required with regard to this provision of the Settlement Agreement, with the departure of the Unified Records Coordinator, the Facility was in the process of rebuilding some of the systems that had been in place. A corrective action plan had been developed and implemented to address the timely inclusion of assessments in the records. However, more specific plans likely would be needed once more extensive analysis was completed. The Facility remained out of compliance with this provision.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The Monitors and the parties agreed to a list of actions that the SSLCs would engage in to demonstrate substantial compliance with this provision item. CCSSLC had not incorporated this structure into their internal monitoring. Based on interview with Facility staff, this was an area they recognized needed additional work. The following represent the Monitoring Team's findings: ▪ **Records are accessible to staff, clinicians, and others**: Although CCSSLC was not yet self-assessing this, the Monitoring Team observed that: o On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive. o As noted in the Monitoring Team's previous reports, to address issues related to the timely filing of information needed to make decisions, CCSSLC had developed a process to track the submission and timely filing of information in the Active Record. The impact of this policy and the related efforts appeared to have been significant. This process appeared to have improved the accountability for the timely filing of documents in the records. However, as the Facility's monitoring activities showed, some issues continued to exist with the timely availability of documents in Active Records. The new system was helpful in identifying where problems had occurred, increasing accountability. o Generally, it appeared that records were available in the residences, and, as needed, at clinic appointments, in individuals' meetings, etc.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ **Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)**: The Monitoring Team observed some problems. For example: o Recording of data is a key part of recordkeeping, and the integrity of such data collection is key to the clinical decision-making process. For example, the Monitoring Team regularly found that nursing staff were not adequately documenting ongoing assessments and/or the results of such assessments. o Work continued with various departments, such as skill acquisition, psychology, and nursing to improve the data that staff maintained. ▪ **Staff surveyed/asked indicate how the unified record is used as per this provision item:** It was not clear whether or not this activity was still ongoing. ▪ **Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item:** The Facility had not yet developed a process for incorporating information regarding the use of records during relevant meetings into the monitoring or database for Section V.4. As discussed in previous reports, this should include observations of a variety of meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, ISP meetings, etc.). The Unified Records Coordinators might not do this, but such indicators might be distributed in other monitoring tools, and the data fed back to the Records Department. Based on the Monitoring Team's observations and record reviews: o As discussed with regard to Section F and Section I of the Settlement Agreement, although improvement was seen, ISPs and integrated health care plans continued to lack consistent evidence of teams making data-based decisions. Although progress was being made, the Facility remained out of compliance with this provision. Teams were not consistently using data to make decisions, and the quality of data and information in the records often was not adequate to allow teams to make well-informed decisions.	

List of Acronyms

Acronym/ Symbol	Meaning
≥	Greater than or equal to
≤	Less than or equal to
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ADLS	Assessment-Discussion-Skill Plan Link
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Antiepileptic Drug
AED	Automated External Defibrillator
AFO	Ankle Foot Orthotic
ALS	Adult Life Skills
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
APEN	Aspiration Pneumonia Enteral Nutrition
APS	Adult Protective Services
ASHA	American Speech and Hearing Association
AT	Assistive Technology
BACB	Behavior Analyst Certification Board
BCABA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BHA	Behavioral Health Assessment
BID	Twice a Day
BiPAP	Bilevel Positive Airway Pressure
BM	Bowel Movement
BMI	Body Mass Index
BMP	Basic Metabolic Panel
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BUN	Blood Urea Nitrogen
c	With
CAP	Corrective Action Plan
cc	Cubic Centimeters
CCC	Competency of Clinical Certification
CBC	Complete Blood Count
CCSSLC	Corpus Christi State Supported Living Center
CD	Communication Dictionary
C-Diff	Clostridium difficile

CDC	Centers for Disease Control
CEU	Continuing Education Units
CIP	Crisis Intervention Plan
CIR	Client's Information Record
CIRP	Crisis Intervention Restraint Plan
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic Obstructive Pulmonary Disease
CoS	Change of Status
COTA	Certified Occupational Therapy Aide
CPA	Comprehensive Psychological Assessment
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation
CPE	Comprehensive Psychiatric Evaluation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTD	Competency Training Department
CV	Curricula Vitae
CWS	Certified Wound Specialist
DADS	Texas Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
d/c	Discontinued
DCP	Direct Care Professional
DEXA	Dual-energy x-ray absorptiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
DM-ID	Diagnostic Manual of Intellectual Disability
DPN	Dental Progress Note
DRA	Differential Reinforcement of Alternative Behavior
DRO	Differential Reinforcement of Other Behavior
DRR	Drug Regimen Reviews
DRM	Dining Room Monitor
DRT	Dining Room Transporter
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
DSP	Direct Support Professional

DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
ECFMG	Educational Commission for Foreign Medical Graduates
ECU	Environmental Control Unit
EDO	Evening Duty Officer
EDWR	Established Desired Weight Range
EEG	Electroencephalogram
EGD	Esophagogastroduodenoscopies
EKG	Electrocardiogram
EMS	Emergency Medical Services
ENT	Ear, Nose, and Throat
ER	Emergency Room
FACCWS	Fellow of The College of Certified Wound Specialists
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FDA	Federal Drug Administration
FNP	Family Nurse Practitioner
FSA	Functional Skills Assessment
FTE	Full-time Equivalent
GERD	Gastroesophageal Reflux Disease
GFR	Glomerular Filtration Rate
GI	Gastrointestinal
G-tube	Gastrostomy tube
G/J-tube	Gastrostomy/Jejunostomy or transgastric feeding tube
HCG	Health Care Guidelines
HCS	Home and Community-Based Services
HDS	Home Dining Supervisor
Hgb A1C	Hemoglobin A1C
HIV	Human Immunodeficiency Virus
HMP	Health Management Plan
HMT	Health Monitoring Tools
h/o	History of
HOBE	Head of Bed Elevation
HRC	Human Rights Committee
hs	At night
HT	Habilitation Therapies
IBWR	Ideal Body Weight Range
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICD	International Classification of Diseases
ICF/MR	Intermediate Care Facilities for persons with Mental Retardation
ICST	Integrated Clinical Services Team

ID/DD	Intellectual Disabilities/Developmental Disabilities
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IHCP	Integrated Health Care Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intramuscular
IM	Incident Management
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IOA	Inter-observer Agreement
IPN	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
ITC	Integrity Treatment Checklists
IV	Intravenous
J-tube	Jejunostomy feeding tube
LA	Local Authority
LAR	Legally Authorized Representative
LON	Level of Need
LOS	Level of Supervision
LVN	Licensed Vocational Nurse
LRA	Labor Relations Alternatives
MAR	Medication Administration Record
MAS	Motivation Assessment Scale
MBS(S)	Modified Barium Swallow Study
MD	Medical Doctor
mg	Milligrams
MH	Mental Health
MHMR	Mental Health Mental Retardation
ml	milliliters
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MR	Mental Retardation
MRI	Magnetic Resonance Imaging
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
n	Sample of the Population Audited
N	Total Population Being Reviewed
NADD	National Association of Dual Diagnosis

NCP	Nursing Care Plan
NM	Nutritional Management
NMT	Nutritional Management Team
NOO	Nursing Operational Officer
NOS	Not Otherwise Specified
NP	Nurse Practitioner
NPO	Nothing by Mouth
NSAID	Non-Steroidal Anti-Inflammatory Drugs
O2	Oxygen
OCD	Obsessive Compulsive Disorder
OHR	Oral Health Rating
OIG	Office of Inspector General
OJT	On-the-Job Training
ORIF	Open reduction internal fixation
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Adaptive Living Skills
PBSP	Positive Behavior Support Plan
PCM	Program Compliance Monitor
PCN	Program Compliance Nurse
PCP	Primary Care Practitioner
PECS	Picture Exchange Communication System
PEG	Percutaneous Endoscopic Gastrostomy
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PIT	Performance Improvement Team
PMAB	Prevention and Management of Aggressive Behavior
PMM	Post-Move Monitor
PMR-SIB	Protective Mechanical Restraints for Self-Injurious Behavior
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team
PNS	Physical and Nutritional Supports
PO	By mouth
POI	Plan of Implementation
PPD	Purified Protein Derivative
PPI	Proton-pump Inhibitor
PRN	Pro re nata (as needed)
PSI	Preferences and Strengths Inventory
PSR	Psychiatric Services Review

PST	Personal Support Team
PT	Physical Therapist
P&T	Pharmacy and Therapeutics
PTA	Physical Therapist Assistant
PTP	Psychiatric Treatment Plan
RAT	Review Authority Team
RATM	Review Authority Team Meeting
RCP	Respiratory Care Practitioner
REACT	Respiration, Energy, Alertness, Circulation, and Temperature
RD	Registered Dietician
RN	Registered Nurse
RO	Rule Out
ROM	Range of Motion
RPC	Restrictive Practices Committee
RPH	Registered Pharmacist
RRC	Restraint Reduction Committee
RT	Respiratory Therapist
RTT	Residential Treatment Technician
q	Each
QA	Quality Assurance
QA/QI	Quality Assurance/Quality Improvement
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QID	Four times a day
QIDP	Qualified Intellectual Disabilities Professional
QMRP	Qualified Mental Retardation Professional
RN	Registered Nurse
SA	Settlement Agreement in U.S. v. Texas
SA	Speech Assistant
SAC	Settlement Agreement Coordinator
SAMS	Self-Administration of Medication
SAO	Skill Acquisition Objective
SAP	Skill Acquisition Plan
SARC	Skill Acquisition Review Committee
Sd	Discriminative Stimuli
SEPR	Supplemental External Peer Review
SFBA	Structural Functional Behavior Assessment
SIB	Self-Injurious Behavior
SLP	Speech and Language Pathologist
SLPA	Speech Language Pathology Assistant
SOAP	Subjective, Objective, Assessment, and Plan

SPCI	Safety Plans for Crisis Intervention
SPO	Specific Program Objective
SRB	Socially Responsible Behavior
SSLC	State Supported Living Center
SSO	Staff Service Objective
Stat	Immediately
STD	Sexually-transmitted disease
UGI	Upper Gastrointestinal
UI	Unusual Incident
UIMRT	Unit Incident Management Review Team
UIR	Unusual Incident Report
UNT	University of North Texas
UTI	Urinary Tract Infection
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
TWR	Temporary Work Reassignment
UA	Urinalysis
UTI	Urinary Tract Infection
VFS	Video Fluoroscopy Study
VNS	Vagal Nerve Stimulator
WAIS	Wechsler Adult Intelligence Scale
WBC	White Blood Count
WC	Wheel Chair